Lecture
ON
DISEASES OF THE CHEST WALLS
REQUIRING
SURGICAL TREATMENT.

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BY JOHN MARSHALL, F.R.S.,

PROFESSOR OF SURGERY AT UNIVERSITY COLLEGE AND SENIOR SURGEON TO THE HOSPITAL, CONSULTING SURGEON TO THE HOSPITAL FOR CONSUMPTION, BROMPTON.

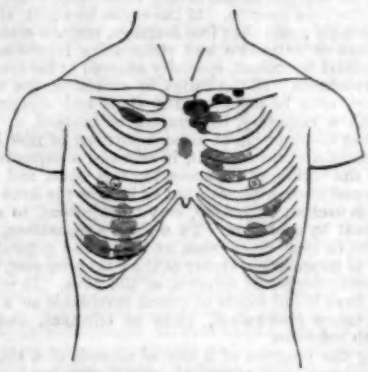
(*Reported by* HENRY MAUDSLEY, M.B.Lond., *and revised by the Lecturer.*)

LECTURE I.—PART II.

Now, in none of the preceding cases was there any taint of syphilis, that is to say, of acquired syphilis; for in the last patient there may have been some congenitally transmitted condition of that nature. But if we direct our attention to cases dependent upon previously acquired syphilis, we find them presenting marked peculiarities. Thus they nearly always occur in women, and they show a decided preference to a certain locality—this being the sternum, and especially the upper part of that bone. I am sure that of any twelve instances of syphilitic disease of the chest walls, nine or ten will be in the sternum, and of these seven or eight at the upper end, in the manubrium, perhaps also involving the first rib, or even the clavicle. The disease commences by a periosteal gumma, which is not necessarily painful, except at its characteristic after-midnight hour. These gummata are fixed, and at first firm, and when after a time they soften in the centre, it is by a process of degeneration and death of the deeper parts, associated with suppuration, not by a purely suppurative process such as occurs in an acute necrosis or a subacute strumous caries. The superjacent integument reddens, thins, and ulcerates widely, leaving a large circular opening, not a mere perforation, as in ordinary caries or necrosis. Sloughs and pus escape, not pus alone; and instead of the sinuses remaining with small apertures, or gradually contracting as if disposed to heal, the tendency in these syphilitic cases is towards a continuous ulcerative process, which spreads out with curved borders, thus affecting the bones as well as the soft parts. When healed, these syphilitic ulcers leave not mere puckered indentations, but large, ugly, depressed scars, indicative of loss of substance. The caries of syphilis is distinguished by the hardness of the eroding bone, quite unlike the soft, easily crushed bone of strumous or tubercular caries. As already stated, I would name it *hard* caries.

I have lately had under observation two cases of syphilitic disease (one at University College Hospital, the other elsewhere) of the upper part of the sternum, almost exactly corresponding in all particulars. They originated in syphilitic gummata, which broke down and left circular ulcers, with carious and necrosed bone beneath them. These two cases (7 and 8) occurred in women. I have been disappointed in not being able to show one of them here. A third case (9), recently brought under my notice, was also presumably dependent on constitutional syphilis, acquired during pregnancy. It was an example of extensive necrosis, with hard caries of the right first rib. There was considerable swelling, with great tenderness and surrounding pain in the subclavicular and mammary regions; in the centre of this swelling was a depressed sore, with very indurated tissues around it, yielding an unhealthy discharge, and leading upwards to a cavity beneath the first rib, a large portion of which was exposed, rough, and hard. Under the influence of iodide of potassium, these several conditions have improved, and the bone appears to have become covered. The two first-named cases were completely cured by healing of the ulcers, with, of course, great disfigurement, under full and continued doses of the iodides of potassium and of iron.

Permit me, now, to make some general observations on the cases here brought to your notice. It will be noted, first, that with one exception the patients are adults. It has been said that caries and necrosis of the ribs are more common in old than in middle-aged persons; but this has not been so in my experience. With regard to the sex, in my cases the females outnumber the males; but I should be unwilling to say that this is the rule, excepting in the case of syphilitic disease: it may be accidental. Of more importance is the situation of the disease. If we exclude the syphilitic cases, ordinary caries or necrosis occurring in the ribs is more frequent at the front than at the sides of the chest, and much more frequent in the lower than in the upper part. The reason of this may be that the anterior portions of the lower ribs not being so thickly covered with muscles as the upper ribs, or the hinder parts of all the ribs, which are so well padded by the pectorals, the great serratus, the latissimus dorsi and the spinal muscles, are more affected by pressure from the dress or other external agencies, and to wet and cold from atmospheric changes. The preference of syphilitic inflammation for the upper part of the sternum may be due to this part of the chest being relatively more exposed to cold, especially with the female dress; or it may be partly determined by the fact that all the actions of the upper limb pivot through the collar-bone on to the sterno-clavicular articulation, and thus throw stress on the upper part of the sternum. The two women mentioned above had been domestic servants, and accustomed to lift weights and to scrub and wash. The oval shape, oblique direction, and fixed position of costal abscesses are very characteristic. They are at first rounded, small, and firm, but as they gradually or quickly enlarge and soften, they always spread along a rib, detaching the periosteum and so causing caries or necrosis. Often at first exceedingly painful, owing to the stretching of the periosteum, fasciæ, and intercostal nerves, the pain diminishes as the periosteum is separated, as the muscles and fasciæ become thinned and less resistant, and the nerves no longer strained. After a time they may become painless, but usually they give pain in the act of coughing, or when they are handled. In the case mentioned as having been treated for intercostal neuralgia, the pain no doubt was of a neuralgic character, owing to stretching or other implication of the intercostal nerves. Costal periostitis or osteitis may end in resolution, but this is rare, the subperiosteal exudation being very seldom indeed absorbed. The suppurative termination, which is usual, generally ends in more or less of caries or necrosis. As a rule, as already mentioned, the acute inflammations lead to necrosis, the subacute or chronic to caries, or a mixture of caries with necrosis. A costal or sternal abscess may commence near and extend into a costo-sternal articulation. If left to open itself, it leaves a narrow sinus, which may discharge for weeks, months, or years, or even for the rest of the patient's life; for many cases are very intractable, owing to the deep position of the caries or necrosis on the inner surface of the rib.



This diagram has been constructed by plotting out the situation of the costal and sternal abscesses in all the cases mentioned in this lecture. The syphilitic cases are indicated by darker spots.

As to the treatment of these cases, it may be said that any attempt at abortive treatment is almost useless. They nearly always run their course, and come to an almost uniform conclusion. In spite of the application of iodine, or iodide of lead ointment, or mercurial ointments, or blisters, or other absorbents or counter-irritants, suppuration almost

inevitably occurs, owing chiefly to some unfavourable concurrent constitutional condition, but also in some measure to the impossibility of keeping the parts sufficiently at rest. We breathe eighteen times in a minute, and the ribs are perpetually disturbed up and down, and therefore twice as many times in a minute; night and day there is no rest for them; and it is not surprising, therefore, that there should be so little tendency in costal inflammations to resolution and cure. A diseased limb or joint we can, by means of splints, keep absolutely at rest, and thus favour the processes of repair; but not so with the ribs. For a similar reason, established caries of the ribs is difficult to arrest and cure; and, in the event of necrosis, the dead bone takes a very long time, even years, to separate, or before it can be detached, for the necrosis is more or less prone to be progressive.

The most judicious treatment is to wait until these costal abscesses are ripe, and then to open them antiseptically along a rib, or near its upper border, or in the case of a sternal abscess, vertically along or near the border of the sternum. As a good precaution in sternal abscess, a raspatory or director may be used after an incision has been made through the skin. The strict antiseptic method is not absolutely necessary; but if the abscesses be large or numerous we may adopt it. If only of moderate size, they do as well with simple antiseptic dressings and perfect drainage. After opening them, it is often difficult or impossible to determine at once whether there be caries or necrosis, or both, owing to the deep position of these conditions on the inner surface of the rib. The search should be made with a probe bent in different curves, and at last it may come upon bone, soft or hard, as the case may be. If the caries be slight, it should be left to itself; and then free drainage, surgical cleanliness, and the use of antiseptic and stimulating injections, with constitutional treatment, specially adapted to the case, are of chief importance. If the caries be extensive, the softened bone may, after laying open the sinus and separating its walls with a raspatory, be scraped, or scooped, or gouged away; but the removal of carious portions of ribs is not a very successful operation. If, in necrosis, a sequestrum lies loose at the bottom of the sinus, lay this open, and remove the loosened piece or pieces; but so long as the dead bone is fixed, it is useless, or, indeed, may be injurious, to attempt its removal by operation. To assist its separation, I have more faith in local cleanliness, and local and general means adapted to improve the vigour of the vital processes, than in any hitherto suggested solvents of the bone. In syphilitic cases, I have found iodide of starch invaluable as a topical remedy, more economical, quite as effectual, and much safer than iodoform.

During the progress of a case of necrosis of a rib, before the sequestrum has separated, much new bone may be thrown out, especially on the outer surface and margins of the rib. Hardly ever does this happen on the inner surface of a rib, which, moreover, is more frequently necrosed than the outer. This inner surface, indeed, has much less nutritive activity and reparative power than the outer surface. Its substance is more compact and less vascular, and its periosteal covering is in contact only with the loose subpleural connective tissue, whilst the borders and the outer surface have muscular attachments blending directly with their periosteal covering. Hence the blood-supply of these parts of a rib is more assured than that of the inner surface, and they display a greater reparative activity. Even in fractured ribs the roughest part of the callus is thrown out on the outer surface and the margins of the bones, and the smoother part on the inner surface, and for the same reason. This result has been regarded as a special provision for the avoidance of pressure or rubbing against the lungs, and no doubt it is an incidental advantage; but this view furnishes no explanation of the fact. The cause is to be sought in the relatively less abundant blood-supply and lower nutritive activity of the deep surfaces of the ribs. Owing to these conditions, also, internal necrosis of the ribs commonly lasts for months or years. Both the ribs and the sternum have been trephined, or portions of these bones have been removed by gouge, saw, or cutting forceps, in order to reach a deep-seated sequestrum; and such proceedings are justifiable if one is sure that the sequestrum is loose. But I would advise great caution in dealing thus with these bones, as it may lead to serious after-consequences. Fatal pleurisy and pericarditis, and septicæmia have followed such operations. There is also on record a case of fatal peritonitis after an attempt to remove a necrosed xiphoid cartilage. Besides, if a rib sequestrum be loose, it may probably be quite easily lifted or tilted out without trephining. As to resection of a portion of a rib in its whole thickness, for caries or necrosis, this also is an operation which must be undertaken with caution; for out of thirty-seven cases collected by Heyfelder eight proved fatal.

It is now necessary that I should advert, however briefly, to the New Growths or Tumours of the chest walls. Examples of most of these are on the table before you. Here are four separate specimens, catalogued as being of medullary cancer, two from the sternum, one from a rib, and another from the frontal bone, all from the same patient. They are multiple tumours, probably cancerous, but possibly sarcomatous, for there is no account of their microscopic structure. In this smaller specimen we find a cancerous nodule just inside the sternum, the result of dissemination of that disease. Here, again, is a large possibly cancerous tumour, which commenced in the sternum, but has grown forwards through that bone, and backwards into the mediastinum, and has actually invaded the lung. This additional preparation shows an interstitial growth in a rib, apparently a sarcoma; and this other, an external periosteal sarcoma of melanotic character. In none of these cases would operative interference have been justifiable. Some are examples of generalised or diffused disease; and in others the tumours were so adherent to the under-lying parts that it would have been impossible to remove them completely, which, as you know, is essential in such cases, without incurring unwarrantable risk.

A simple exostosis of the sternum, or of the ribs, is very rare. Here is an example of a small exostosis situated on the neck of a rib. It probably gave rise to no symptoms during life, and from its position it would have been inaccessible to operation. Enchondromas of the ribs or sternum are now and then met with; but unless the enlargement of this horse's rib be of that character, I have no museum specimen to show you. The hard enchondromata usually grow from a rib, and the softer forms from the sternum; the latter may become cystic, and the former may ossify, and so become exostoses. The hard enchondromata may be painful, and, if pedunculated, may be dissected off; if sessile, the diseased portion of the rib may be carefully resected. The soft enchondromata, usually less painful, may grow to a large size, and hence are serious. It is better therefore to remove them early, with a part of the bone to which they are attached; or, at all events, as soon as they exhibit any rapidity of growth. There is, however, some risk in such operations, for there is no subjacent inflammatory thickening of the pleura or pericardium, which in diseases of an inflammatory nature serves to protect the underlying cavities and organs. Accordingly, wound of the pericardium, and wound of the pleura with prolapse of lung, have occurred in resecting an enchondromatous rib. Nevertheless, if the tumour be growing rapidly, the rib had better be carefully resected.

CASE 7.—In concluding this lecture I am enabled to bring to your notice a patient sent to me last summer by my friend Mr. Steil; she is suffering from some form of new growth upon the ribs. She is twenty-four years of age and unmarried. Her father is now in a lunatic asylum; her mother is healthy; one sister is said to have died of goitre, and another from a tumour of the head. One brother died of consumption. The survivors, a brother and sister, are fairly healthy. You will observe that there has been slight rickets, for the sternum and the costal cartilages are rather prominent, and the ends of the ribs are somewhat enlarged. This enlargement, seen immediately below and to the inner side of the left mamma, is of twelve months' duration, and was at first supposed by the patient to be a tumour of the breast. There is here a firm circumscribed oval swelling, consisting of a smaller upper part, and a larger, prominent, and somewhat softer part below. Seven or eight months since I passed a grooved needle into this softer part, but obtained no serum, no pus, but only a drop of blood. The tumour is really double, consisting of a smaller, hard part attached to the anterior end of the left fourth rib, and a larger, softer part connected with the fifth rib very close to the cartilage. They are everywhere excessively tender, and cause great pain on coughing, or on exertion of the corresponding arm. These symptoms are due probably to pressure on the intercostal nerves. I scarcely think they are hard enough for pure enchondroma, and yet they are of too slow growth for soft enchondroma, or for subperiosteal sarcoma. Confirmatory of their neoplastic character, I may observe that there seems to be some obscure and deep-seated growth forming in the left

mastoid region; for the left auricle is being gradually pushed away from the head, and, as may be seen on looking at the patient from front or behind, the left ear is now distinctly more prominent than the right. The space below the lobe of the ear, in front of the mastoid process, is fuller than on the opposite side; and the left condyle of the lower jaw projects unduly. There is also pain in this region. Recurring to the rib tumours, their treatment must be almost entirely expectant. Their close proximity to the pericardium, taken together with the manifestations of another deep-seated growth at the basis cranii, preclude any operation, unless it were undertaken to mitigate otherwise uncontrollable suffering, or to prolong life,—neither of which requirements is at present indicated. Absorbent and alterative treatment of every possible kind has been without service; but in some form or other it will be continued.

Clinical Lecture
ON
A CASE OF PNEUMONIA WITH TYPHOID SYMPTOMS.

Delivered at Westminster Hospital,

BY OCTAVIUS STURGES, M.D.,
PHYSICIAN TO THE HOSPITAL, AND JOINT LECTURER IN MEDICINE.

GENTLEMEN,—It is commonly said when two conditions of disease occur in succession that the one which appears latest is a complication of the other. Pericarditis is a complication of acute rheumatism, bronchitis of gout, pneumonia of enteric fever. It is obvious, however, that this mode of expression is only appropriate where the two affections are of independent origin, and separate in cause as well as in seat. Hence the suitability or otherwise of the word "complication" as applied to any particular symptom is an element in diagnosis; it cannot be determined without a competent knowledge of the proper features of disease and their range of variation. It will sometimes happen that symptoms which we are accustomed to see associated, and on that account to refer to a single agency, become ambiguous and difficult of interpretation owing to the anomalous relationship which they bear to one another. Thus, for instance, inflammation of the lungs is sometimes associated with enteric fever; but the mere fact of conjunction is no proof of any real kindred between the two affections. It needs besides that *the manner* of association should be of a certain kind. A patient of ours illustrates this principle so well, and at the same time exhibits an aspect of pneumonia of so much interest and importance, that I cannot do better than make him the subject of this afternoon's lecture.

The case is shortly as follows:—A stout, healthy youth of sixteen, a porter, who had been complaining of slight cold for some weeks, was seized with shivering on January 1st while at his work. He had headache, pleural pain, and complete loss of appetite; and on the third day, when first seen, but before admission, his face was flushed, skin hot and pungent, respiration rapid and jerking, with much pain on inspiration, and very frequent pulse. With all the aspect of pneumonia, no auscultatory signs of the disease were as yet audible. Admitted on the 4th (days of disease corresponding with those of the month); pulse was 132, full, bounding; respiration 45; temperature 105·2°. Dulness, tubular breathing, and fine crepitation were now present over the right chest anteriorly from clavicle nearly to nipple. The tongue was red, moist, and white-furred. Pain in the side still severe. The further progress of the case was marked *physically* by some extension in the area of lung consolidation, and *generally* by restlessness, night delirium, and intense thirst; the temperature each day up to and including the sixth, ranging between 104° and 105·2°; the pulse varied between 140 and 125. There was a trace of albumen in the urine. The bowels had been somewhat loose from the time of admission; but not until the sixth day did the patient exhibit signs of enteric fever. This now appeared both in the character of the evacuations and their increased frequency, together with distension of the abdomen, and some doubtful spots. With this the temperature began to fall, so that on the 8th its highest point was below 103°; while the respiration reached 60. The delirium was constant and at times violent, so that little sleep was procured. On the evening of the 8th, the diarrhœa suddenly stopped. But it was now plain that the boy was dying. Death occurred on the tenth day from his first seizure, and the fifth or sixth from the first appearance of enteric symptoms; the illness throughout maintaining the characteristics of pneumonia rather than of typhoid fever. It may be added that the family history afforded no evidence of phthisis or scrofula, and that there was no known source of infection.

The leading features of the post-mortem examination, stated in the same summary way as the symptoms during life, were these:—The right lung was uniformly consolidated in its upper half, red passing into grey, the lung tissue in parts destroyed. Covering the lung was a bulky and consistent layer of recent lymph; the cavity of the right pleura contained three or four ounces of clear fluid. The left lung was congested merely. On examination of the small intestines these presented the characteristic signs of enteric fever in an early stage, the solitary glands being enlarged, and Peyer's patches raised, and at one spot superficially softened. The large intestines were unaffected. The kidneys, heart, spleen, and other organs were natural.

Now, the symptoms which were most prominent and the earliest in this case, both locally and generally, were those of pneumonia. The flushed face, the stitch, and the temperature were all suggestive of that affection, even before the physical signs directly indicated it. It is not until the sixth day, and when the illness had begun to threaten a fatal termination, that the signs of enteric fever appear in diarrhœa, abdominal distension, and some doubtful spots. Even then the violent delirium, the pleural pain, and the time and manner of death resemble pneumonia most. And after death the doubt as to the relationship of the fever and the lung inflammation is not immediately resolved; for there are the signs of simple pleuro-pneumonia along with the signs of commencing ulceration of the bowel. What we have to determine, therefore, is this: Have we here simply enteric fever involving, or, as some would say, complicated with, pneumonia, the pulmonary inflammation being unusually early and unusually prominent; or have we two distinct and independent diseases, which happen by chance to concur in the same individual; or have we, in the third place, a true pleuro-pneumonia of pythogenic origin, and which, in consequence of that origin, exhibits towards its close those enteric symptoms which we commonly associate with the typhoid poison? I think, and I will try to show, that this last hypothesis is the most tenable.

That the two conditions here conjoined are altogether independent of one another may indeed be true, but it is a way out of the difficulty which can only be accepted in the last resource. It is no new experience to find enteric fever and inflammation of the lungs in company. Assuming, however, the lung condition to be part and parcel of the enteric fever, what requires explanation is this: first, that the acute pneumonic symptoms preceded by five or six days those of the specific fever; and next that this pneumonia, thus appearing out of its time, is a lobar pleuro-pneumonia. The question is, Do we find such a pneumonia, as to time and as to form, among the recognised phenomena of typhoid fever?

That pneumonia is amongst the admitted "complications and sequelæ" of enteric fever I have already said. Dr. Murchison met with it in 13 per cent. of his cases, and Dr. Flint in about 16 per cent. But invariably the pneumonia is subsequent to the appearance of the enteric symptoms; and invariably it is lobular and not lobar. Dr. Murchison, indeed, remarks that this enteric pneumonia "is usually lobular." I would venture to assert, and upon his own authority, that it is nearly always both lobular and double, and that a one-sided lobar pleuro-pneumonia is almost if not altogether unknown in enteric fever. If to this it be added that the pneumonia in our present case did not so much accompany as precede the symptoms of enteric fever, no fair review of the facts will conclude that the former is a mere "complication" of the latter.[1] What remains, then, but to suppose

[1] See Murchison on Fevers, Cases 28 and 29. At p. 94 of the "Natural History of Pneumonia" the question of the character of the pneumonia which attends typhoid and typhus fever is fully discussed from the point of view of statistics.

that we have here a true lobar pneumonia of pythogenic origin, and that whatever is exceptional or unusual about it—the condition of the bowel and the fatal termination of the illness—is due to the exceptional character of the exciting cause.

We make a very proper and useful distinction in separating the simple pneumonia, which has a definite course and duration, from the numerous forms of lung inflammation, which have so many issues and modes of progress that they admit of no clinical description. Yet it must be remembered that the orderly course of so-called simple pneumonia and its conformity to a single pattern is not always maintained. Nothing is more striking or mysterious than the invasion sometimes of a small area of lung by inflammation after the manner of ordinary pneumonia, and next—when, in reliance upon the observed rule of the disease, we are expecting subsidence of fever, resolution on the part of the lung, and speedy recovery—either rapid destruction of lung tissue, or else grave prostration, altogether out of proportion to the extent of the local mischief; and either way death. There can be no stronger contrast than that between the ordinary recovering pneumonia and this virulent and unrelenting process of destruction, whether of the lung itself or of the vital power. Yet these two conditions happen to individuals of the same kind, they have the same objective signs, and at the outset are indistinguishable. In the end we are content to call both by the same name, the one of a good type, the other of a bad.

It is true that we have learnt of late to look beyond the objective signs of pneumonia in order to discover its full meaning. Habitual intemperance, destitution, old age, are among the conditions best recognised as exercising an important influence over the course and final issue of pneumonia, no matter how "simple" in form, or how limited in local expression. Yet no one will say that all the cases which err from the common rule are provided for under these categories. The case we are now discussing is not so provided for. It is clear, then, that more is to be made out as to those exciting or contributing causes which, like alcohol, or privation, may seriously modify the course of a pneumonia which in itself is in no way distinguishable from that which is due to external chill. The present case suggests that amongst these causes the pythogenic must be included, and that when of this origin the ultimate issue of pleuro-pneumonia, however frank its expression and however insignificant the area of lung at first implicated, cannot be confidently predicted.

I am not proposing in the light of a new doctrine that there is a form of pneumonia which is sometimes of pythogenic origin. As long ago as 1874 Drs. Grimshaw and Moore called attention to the fact. Both an epidemic and a contagious[2] pneumonia have been contended for. But I instance this example of ours because the existence of a true lobar pneumonia of this origin is not generally recognised. On the contrary, those authors who insist upon this source of pulmonary inflammation are careful to add that it is not lobar or croupous pneumonia that they mean, but that much wider and less precise affection which is commonly lobular in form, extending to both lungs and exhibiting morbid changes of other organs. There can be no difficulty whatever in admitting that pulmonary inflammation of this form may be the chief or, indeed, the sole expression of a poison similar to, if not identical with, that of enteric fever. If, indeed, you extend the view of epidemic disease beyond our own country and the present time—if, in a word, you read a book more quoted, I think, than any other without acknowledgment: Ozanam's "History of Epidemics,"—you will find descriptions of many popular illnesses of this kind appearing in Europe both in ancient and modern history. The gathering together of large armies, privation due to famine or to war, even the importation from a distance of an infected individual, have repeatedly given the signal for such epidemics, of which the main symptoms have been blood-spitting and pain in the side. Epidemic pneumonia of this form is as old as the plague of Athens. In most instances of the kind, however, inspection after death revealed a general hyperæmia or a gangrenous destruction affecting both lungs, and having little in common with what we now call pneumonia. It must be added, at the same time, that there are instances on record which, both in symptoms and post-mortem appearances, so far as can be judged from the scanty knowledge of the day, corresponded with the disease we now see.

But without dwelling on the precarious records of the Middle Ages I could mention in detail, if time permitted, the epidemic occurrence of pneumonia, of a sort which it would be mere pedantry to attempt to distinguish from true lobar pneumonia, and its spreading as though by contagion from one to another. In some of these cases the atmospheric conditions were by no means those which are known to favour the prevalence of pneumonia, nor was that disease generally prevalent. The affection has attached itself to a single house or district, and although in many instances no distinct source of infection was discovered, the hypothesis of its originating in some more general way seemed to be contradicted by the health of the neighbourhood. Yet still the question arises, Granting that lobar pneumonia may occur sometimes in an epidemic form apart from those causes which commonly invite it, upon what evidence is it to be regarded as pythogenic? If it be answered upon the evidence afforded by the presence of typhoid ulceration, it may fairly be said in rejoinder that such a combination is highly exceptional. If the pythogenic origin of pneumonia is only to be accepted when it occurs, as in our present case, along with well-recognised enteric signs indicative of its source, in that case we shall have to admit that its occurrence, whether epidemically or otherwise, is rare enough.

Now I put it to you whether we are really justified in asking as much as this. Assuming that the typhoid poison exhibits itself sometimes in the lungs by means of a veritable pleuro-pneumonia, I fail to see on what grounds it is necessary that this same poison should at the same time give rise to those specific enteric lesions by means of which it is commonly announced. What is the law, or rather, the common habit of disease in this respect? Is it not that a poison present in the system and capable of various local expressions will express itself in one place rather than in several, or at least in one place at a time? Take the poison of gout which appears at first in certain joints and presently in the bronchial mucous membrane, the one inflammation awaiting the disappearance of the other. Observe how the prodromal symptoms of a gouty attack culminate sometimes through the joints in what we prefer to call proper gout, sometimes in bronchitis and sometimes in eczema. Or take again what our fathers used to call metastasis, the fact—namely, that the sudden disappearance of disturbance in one place will be the signal for its appearance in another and a distant place. Or, apart from any hypothesis of poison, take the case of a material. General tuberculosis implies the presence of grey granulations scattered throughout the body, and yet we find that when inflammation is excited by this means it will not be a general but a local inflammation; the brain, or the lungs, or the peritoneum according to the time of life. And, indeed, we find the same rule prevailing everywhere. Disease phenomena are not so much modified in successive attacks as transmuted. An epileptic fit at one time will correspond with an attack of mania at another time. A neuralgic attack will be replaced by a fit of asthma. And the same sort of transmutation which occurs in the individual is seen as well from father to son, and is well illustrated by the large number of distinct and separate affections which we now recognise as of one kindred and refer to under the name of "neurosis."

It is, I think, in strict accordance with facts like these that the pythogenic poison should exhibit itself in one place at a time. Without denying that the occurrence of typhoid symptoms, as in our present case, helps to determine the origin of a pneumonia when that point would be otherwise doubtful, it is difficult to see how the absence of such symptoms in particular epidemics or certain individuals is inconsistent with what the analogy of disease would lead us to expect.[3] Whether or not there is evidence enough to

[2] It may perhaps be admitted, as contended for by Dr. Daly in a very careful and instructive paper (THE LANCET, Nov. 12th, 1881), that certain forms of pneumonia may be contagious—"communicable, that is, from person to person like scarlatina." But is not this contagiousness associated with acute inflammation of the lungs rather than with true pneumonia, and due to the fact that some admittedly contagious diseases may exhibit pulmonary symptoms which mask their real nature? Dr. Kühn, who in 1878 (see THE LANCET of Aug. 24th, 1878) called attention to an outbreak of contagious pneumonia in Hanover, expressly states that the disease was not a genuine croupous pneumonia, and that it involved other organs besides the lung. Dr. Daly himself mentions that he does not regard the contagiousness of pneumonia as proved.

[3] About three years ago Mr. Couldrey kindly supplied me with some particulars of an epidemic of true pneumonia occurring in his practice at Scunthorpe, and of which he had given a short account in THE LANCET of Nov. 16th, 1878. In every instance it was one-sided, and with consolidation of the affected lung. Its origin seemed to be in the accumu-

establish the existence of a pythogenic form of true lobar pneumonia is a question apart, but the absence of enteric symptoms does nothing to invalidate its claims to recognition. We are, in fact, only just beginning to recognise the doctrine of equivalence and substitution in disease, and to see in the most different symptoms the operation of one and the same spirit. By-and-by we may be able to determine the correlations and limits of variation of many morbid phenomena which are presented to view in such diverse shapes that, with our present knowledge, they are taken to be altogether distinct. Meanwhile there is danger lest in seeking to be exact and compendious in the classification of disease we may pay too much deference to arbitrary and superficial distinctions, and separate what nature has joined together.

In conclusion, there are two practical lessons suggested by the case of our patient, to which I may, in two words, call your attention. The one concerns prognosis, the other treatment. Pneumonia of obscure source is always suspicious; the *frank* origin of the affection, at such time as the season invites it, and from some definite exposure, is more favourable, *cæteris paribus*, than its occurrence after fatigue or mental distress, or from insanitary conditions of living. Further, and in view of what has been said, the occurrence of two or more examples of pneumonia in the same house, especially when the disease is not prevalent around, must always awaken the fear (be the exact truth of the pythogenic hypothesis of pneumonia what it may) that the source, and hence the duration and the result of the disease, may not be such as its mere name would lead us to expect. The removal of such cases where that is feasible, and the duty of inquiry into the sanitary conditions, are points too obvious to dwell upon. And as regards treatment. These patients, when, as sometimes happens, they exhibit enteric symptoms as well as pneumonia, as in our present case, place us in this dilemma, that the treatment suitable for the diarrhœa is not suitable for the lung inflammation. I think in all such instances there is weakness in compromise, and that the safety of the patient is best consulted by the liberal administration of strong beef-tea and other nutrients, as in the case of a simple pneumonia.

OBSERVATIONS ON SOME CONGENITAL DISEASES OF THE EYE.

BY J. F. STREATFEILD, F.R.C.S.,

PROFESSOR OF CLINICAL OPHTHALMIC SURGERY IN UNIVERSITY COLLEGE, LONDON, ETC.

IT has seemed to me that within a short time in the past year, and especially in the latter part of it, I have had, chiefly at the Royal London Ophthalmic (Moorfields) or University College Hospitals, an extraordinary number of cases of some of the congenital diseases of the eye. Many of these cases of malformations and ill-developments are, of course, irremediable; but even then their histories are interesting, and some few such cases may be really benefited by treatment, probably surgical, and then they become very much more interesting. So, for one or the other reason, I have presumed to write out the following cases at some length in order to publish them, and I have tried at the same time not to encumber my notes with any irrelevant details. The twenty-five cases seem to arrange themselves naturally under the following nine heads:

A. *Eyelashes; Partial Whiteness.*

1. Royal London Ophthalmic Hospital (Nov. 1881): This was the case of a woman, aged fifty, requiring glasses for near vision, as to which there was nothing noteworthy. She had dark brown hair and eyelashes of the same colour; but whilst those of the upper and lower lids of the left eye were in this respect all alike, there was a patch of perfectly white lashes, otherwise like the other normal brown hairs, in the row of the right upper lid. In this patch *all* the hairs were white; but there were also a few white hairs, interspersed singly among the coloured eyelashes of both lids of this right eye. The white patch, which she told us had always been as we then saw it, was of about a quarter of an inch of the length of the row of lashes of this lid towards the outer canthus, but not including the outermost, which were coloured.

B. *Lacrymal Apparatus; Absence of Puncta.*

2. In the time of which I am writing I have had more than one case in which, when I have been unable after a long search to find a lacrymal punctum, I have been inclined to say that there never was one there, but this is generally wrong. It has much more probably become obliterated, and is not congenitally deficient. I remember one such case lately in which I supposed the puncta to have been absent from birth, for as well as I could learn the facts the eye had been always inclined to water, there had been no blepharitis, and there was no ectropion or any of the well-known obliterating causes. Certainly I could, with oblique illumination *plus* a magnifying lens, find no trace of either punctum. What is to be done in such a case? I know how to re-establish a (canaliculus and) punctum of either eyelid, if that of the opposite eyelid can be found (see Ophthalmic Hospital Reports, vol. iii., p. 6), but if neither punctum of an eye can be found, it is even more difficult. I took time to consider in this case; I had not made up my mind, and the patient never returned to the hospital.

B. *Lacrymal Apparatus; Double Canaliculus of one Lid.*

3. I have had, last summer, a case in which there were two outer orifices (puncta) of one eyelid, with separate passages (canaliculi) leading inwards therefrom to the lacrymal sac. I am sorry I have mislaid my brief notes of the case, but I have a very good recollection of it. The child was brought to me for a watering of one eye, which had been long observed. On examination I found, in the right place, a normal-looking punctum of the *lower* lid of that eye (the upper punctum is always comparatively unimportant), and also near it on the skin surface another minute orifice, damp with watery fluid. This abnormal secondary punctum, as I must call it, was nearer the inner canthus than the other punctum, which was in the usual situation—about 2 mm. from it, and a little external to a line drawn directly from the normal punctum to the inner canthus. By either of these orifices (puncta) I found I could easily pass a fine probe, and afterwards Weber's knife, into the lacrymal sac. Having thus slit both passages, I afterwards with a probe kept patent only the canaliculus connected with the normally placed punctum. I do not know at what distance from their separate external orifices the two canaliculi were united, if at all, but the abnormal one did not seem to have a direction immediately towards the regular duct; it seemed rather to lead inwards independently to the natural outlet of the tears in the upper part of the lacrymal sac. I must be allowed to remark that a fistulous capillary skin orifice, exuding tears, the result of neglected suppuration of the lacrymal sac, is always at a long distance from (below the tendo oculi, and far below) the situation of this secondary orifice and passage which I have been describing. The lower lid also, in the present case, was perfectly supple, and there was no history of any past inflammation. I believe that in this case, without difficulty, I passed a probe at the same time down the nasal duct; so I do not know the cause of the former lacrymation. According to Professor Horner of Zurich, in his article on the eye diseases of childhood,[1] the above case is only rare in that both canaliculi of this lower lid led into the sac. He says: "Ich habe mehrere Fälle von doppelten Thränencanälchen gesehen und zwar nur am untern Lid; nach innen und unten von dem wirklichen Canälchen findet sich ein zweites, das meist blind endet."

C. *Muscles; Convergent Squint.*

4. The patient was a healthy and very intelligent little boy, of two years and seven months old, with common hypermetropic strabismus, the left eye being constantly inverted, and very much so when looking at near objects. There was no kind of muscular paralysis in this case, and the child had always been in good health. I divided the left, and afterwards also the right, internal rectus tendon, with good result. The father said positively that the child was born so squinting. I should regard this as but an instance

lation of refuse in the rear of the houses affected, and on the removal of this nuisance the epidemic ceased. "In the very next street," writes Mr. Couldrey, "to that in which the pneumonia occurred was an epidemic of diarrhœa, *in no case accompanied with pneumonia*, nearly every house being attacked."

[1] Gerhardt: Handbuch der Kinderkrankheiten, vol. ii., p. 240, 1879.

of the common popular error (that a squint is often congenital) if it were not that Dr. Gresham, who, in August last, came to my house with the child, and who attended the mother when the infant was born, says the squint in this case was congenital—that is to say, that only a very few days after it was born he observed that the child squinted as he did when I first saw the case and operated. But if, correctly, congenital affections and diseases mean only such as exist at the very time when the patient came into the world, I still cannot but doubt if there is such a thing as, of course excluding paralyses, congenital squint. If the present case is not to be called truly congenital—and all the evidence goes to prove that the child was born with the squint,—it is at least a very rare case, and hardly explicable. The child certainly squinted when it was only a few days old; and such little infants seem to observe nothing particularly, and, indeed, seldom open their eyes at all. Why, then, should it squint? And, *à fortiori*, how can there be any congenital cases of squint?

D. *Cornea and Sclerotic; Dermoid Tumour.*

5. Royal London Ophthalmic Hospital (Dec. 19th, 1881): Annie B——, aged eight, was brought with one of these not very uncommon little congenital tumours or growths, or, I should say, the remains, or basis, of one of them, for it had been partially abscissed, and was at this time hardly above the level of the surface of the eyeball from which it had sprung. Her mother brought her to me for a slight catarrhal ophthalmia, to which she said, *in that eye only*, the child was subject. For it I prescribed the ordinary remedies. As to the little tumour, there was no apparent irritation about it, nor history of any such irritation, no pain or tenderness, nor any more redness about the conjunctiva over it than there was elsewhere. I should have been surprised if there had been, for such little growths as this one never, as far as I know, give any real trouble; they are only disfiguring. Rarely indeed do they call for any interference; but in this case I had operated more than once. The projection had been sliced off, the mother reminded me, several times when the patient was very young, because she and I had no doubt it was every way somewhat increasing in size. The mother, indeed, said it used to grow very fast, which I doubt very much; but finding it did grow, I removed it partially, as completely as I could with safety to the eyeball, more than once, when it seemed to me to be necessary. It does not grow now, the mother said, and the surface of it was so little raised above the regular surface of the globe that, as it was quite white, I should probably not have observed it at all but for its encroachment on the cornea; not that in its whiteness or encroachment on the cornea it was at all peculiar, they are chief characteristics of this kind of little congenital tumour. This one was in no way peculiar, but that so little of it now remained, it had hardly any prominence left. It presented a regular very slight convexity, and was *circular in outline*, nearly 6 mm. in diameter. It was *at the sclerotico-corneal junction*, at the lower and inner side of the right eye, about one-third of it being on (and in) *the cornea*, the rest on (and in) the *sclerotic*. It was quite *white, like the sclerotic*, and the *conjunctiva over it was movable*. I proposed to tattoo with Indian ink that part of the white tumour, or the scar of it, which involved the cornea, and was in front of the (dark) iris. It cut, I remember, when it was sliced, like fibro-cartilage (I mean that it offered as much resistance to the knife in cutting), and although it was removed to the level of the normal surface of the eyeball, it was as white there as it appeared superficially.

D. *Cornea and Sclerotic; Buphthalmos.*

6 and 7. Royal London Ophthalmic Hospital (Nov. 14th, 1881): Harriet H——, six months old, was brought by her mother. She had very large and staring eyes, the right eye being considerably the larger of the two. The eyes had been of an unusual size from her birth, the mother told me, and they were getting larger and larger. She was a very healthy-looking child, never crying even when I was examining and carefully manipulating the eyes. At other times she looked at me attentively, or at the lamp as it was moved from one side to the other. The irides were tremulous, with the least movements of the eyes, and in the circumferential parts so much thinned as to be almost transparent with the ophthalmoscopic mirror. The corneæ were perfectly normal in regard to their transparency, and the other and deeper coats of the eyes showed nothing more abnormal than thinning. The pupils were (in proportion to the dimensions of the other parts of the eyes) of moderate size and moderately active. The anterior chambers were shallow. The tension of either eyeball was at least + 2. The whole condition was what I should call total staphyloma, or buphthalmos; all parts of the circumference of the globe being, in either of them taken by itself, *equally* distended. But it was not one of those common cases of buphthalmos, not truly congenital, but a result of ophthalmia neonatorum followed by keratitis, ulceration also probably of the cornea, this being followed by staphyloma corneæ, and finally of the sclerotic also. She had had no ophthalmia and had no trace of corneal opacities in either eye. The increased tension was, as I have said, considerable. I was, by bitter past experience, much disinclined to attempt a cure, or even to imagine an arrest of the disease to be possible by iridectomy or any other surgical interference in such a case, so I prescribed a four-grain solution of the sulphate of eserine to be dropped into the eyes three times a day. The mother then reminded me of the case of another of her children, whom she afterwards brought again to see me, an elder sister of this infant, who was also born with such great eyes as this little one had at birth. At that time, years ago, with excessive tension and increasing enlargement I had iridectomised, as of course, both eyes of her elder daughter. The results were very bad, not only in not arresting the disease, but in her right eye the lens subsequently became displaced laterally, and, in the left there occurred subsequently a considerable hæmorrhage from the iris into the anterior chamber. The left eye got very much larger, became blind and painful so when she was eight years old I had to excise it. She was now thirteen years old and in a blind school. The right eye had gone on enlarging; she had bare perception of light in it; it was as large as two or three normal eyes, but the eyelids, I suppose because of the *gradual* enlargement, were easily shut. The staphylomatous bulging was greatest in the place of the iridectomy scar. The eye was rather painful sometimes, T + 1, or less. She had a slow, irregular lateral nystagmus. Her younger sister had no nystagmus. In neither of these two children had there been, since their births, any kind of inflammation of their eyes.

To go back to the case of the younger child: I ordered eserine drops. I have seen her once since then, on the 19th of December, the eyes were *not so hard, almost of normal tension. I did not think either of them enlarged* since the first time of my seeing the infant; the pupils were contracted, not very small, to the size (diameter) of about 2 mm., they were not tremulous, and as if the intra-ocular pressure originated in the vitreous chamber the irides were now (under the influence of the myotic) evidently stretched very much forwards, beyond the natural plane of the iris, over the convexities of the lenses which, of normal size, appeared to be small, only in the middle of the areæ of the great clear corneæ in front of them. It had a very strange appearance. The anterior chambers were excessively shallow, this condition being now with contracted pupils very marked, I suppose, rather than increased. The benefit got by eserine is well worth noting, for, I believe, not only by observations made in my own practice, that nothing else either done or used for cases of progressive total staphylomata of any kind has even for a time arrested the course of the disease. I hardly venture to hope that in this case it will be *finally* arrested by the eserine. The good effect of eserine in glaucoma is often transitory.

E. *Iris; Colouration.*

8. University College Hospital (May 2nd, 1881): Edith F——, aged sixteen, a pupil teacher, came to me complaining of defective sight, and her mother said she used sometimes to squint. The left eye was somewhat amblyopic; with it she could read only $\frac{1}{12}$, and to spell out 1·25. With the right eye $\frac{5}{12}$ and 0·5 hardly. She was hypermetropic, and as she saw lines *nearly* horizontal most distinctly, she was also astigmatic. With +1·50 D. spherical glasses, and for the right eye a +1·25 cylindrical, and for the left eye a +2·0 cylindrical glass, the axes *nearly* vertical, she could read with the right eye $\frac{2}{3}$ four letters, and with the left $\frac{1}{3}$ all. With these glasses she could read comfortably and continuously. She had in the iris of either eye a remarkable and perfectly symmetrical notch, in appearance as regards the grey colour pigmentation. I do not mean that there was a coloboma; indeed the *angle* of the notch, as I have called it, was *towards*, not from the centre. Her irides were of two greys, strongly contrasted, which divided about

equally between them the width of the iris; the inner half was of a very light grey, with a little hazel here and there, and the rest, the outer half, was *dark* grey. Upwards, and a little inwards, in either iris, in exactly the same situation, and to precisely the same extent, the dark grey outer zone encroached upon the light grey inner circle, and extended inwards so as *almost* to reach at a point the pupillary margin. I suppose it was a mere coincidence, but it was to me very remarkable, that the meridian in either eye indicated by this notch-like patch of dark colouration in her two irides *exactly corresponded with the symmetrical meridians in her eyes of least refraction.*

E. *Iris; Absence of Iris; Irideremia.*

9. Royal London Ophthalmic Hospital (May 26th, 1881): Joshua A——, aged eighteen, came to me with double cataract and total absence of both irides. At first I thought I could perceive, by oblique illumination, some traces, irregular notches, of the extreme outer circumferences of the irides, but these afterwards I believed to be ciliary processes, which were thus brought into view. Between these projections all round, and the peripheral edges of the opaque lenses, in a narrow circle, one looked uninterruptedly with the ophthalmoscopic mirror into the vitreous chambers. The cataracts were grey and most opaque at their centres. He counted fingers only at six inches with the right eye, and with the left only at half that distance. This eye squinted outwards. In other respects the two eyes were ostensibly alike. There was nystagmus. The patient said his father was born blind, and that his eyes were just like his own, but this of course was not ascertained. I am of the opinion of those who say that congenitally defective eyes—at least those in which the defect is not congenital cataract only—do not bear cataract operations at all well, but in this case, with a caution to the patient of the risk incurred and of the kind of improvement to be got by a successful removal of the cataract, I recommended an operation, and then used a cataract needle to the right eye. I intended, of course, to have done very little more at first than lacerate a small part of the anterior lens capsule in the centre, but as soon as it was opened, the cataract was found to be partly fluid, and so much of it was then evacuated by using a broad needle and a curette. Atropine and iced compresses were regularly used. He was sick and in pain during the night, the eyeball very tender, tension increased, and this state was not relieved by leeches. The anterior chamber was, the next day, again tapped with the broad needle, and, with the resecreted aqueous humour, an additional small quantity of the softened cataractous lens matter was let out. On account of the increased tension, as soon as it was discovered, eserine was substituted for the atropine drops. After the second paracentesis and evacuation of lens matter he had no more pain in the eye, but for two or three weeks he had very much congestion in the ciliary region—cyclitis in fact; he could not have iritis—the commonly feared ill result of cataract needling operations—for the best of all possible reasons; and not until a month had elapsed, and atropine again, instead of eserine, had been used, and an occasional blister applied, did the ciliary redness disappear. On the 20th of July the eye was quiet and the tension normal; the fundus could be seen, and there were some remains of the lens. He could see with + 10·0 D., $\frac{6}{9}$, and with + 14·0 D., 4 Sn. I was unwilling to interfere any more with so very peculiar an eye. He got his glasses, and since that time he has never again been to report himself at the hospital.

E. *Iris; Eccentric Pupils.*

10 and 11. Royal London Ophthalmic Hospital (Oct. 24th, 1881): Lydia S——, aged fifteen, came for myopia and a divergent squint in the right eye. In this eye, which was also amblyopic, I found two peculiarities which, I was told, had always existed in it. The pupil, in the first place, was placed eccentrically upwards and inwards, of 5 mm. diameter, and larger than that of the other eye: it was circular and active. The width of the iris, from the pupillary margin to the greater circumference, was in the direction downwards and outwards, about twice as great as in the opposite direction, upwards and inwards. The two shades of the colour of the iris of this eye were, in the second place, remarkable. It is not uncommon to find the iris, at its inner circumference, of quite a different tint from that of the outer circumferential parts, but in this case it was as definitely of two colours, with an irregular notched outline away from the pupil, as are the patches of a piebald horse; and, supposing a meridian line to be drawn through the centre of the cornea, in such a direction that (as I have described the eccentricity) the pupil should be altogether in one of the two halves, the piebald condition of the iris only occupied that half in which the pupil was, and, avoiding altogether the lower and outer half, it did not surround even the margin of the pupil in this direction.

Herbert B——, aged twelve, came to me with chronic interstitial keratitis, probably of inherited syphilitic origin, and trachoma, &c. The corneal opacity was not much in the left eye; the pupil of this eye was eccentric, apparently circular and active, and of moderate size, 3 mm. in diameter in common daylight. The misplacement was down and outwards, and the amount of it was such that no part of the area of the pupil was opposite to the centre of the cornea. Under the influence of atropine—used for the keratitis, for I had no suspicion of iritis, past or present—this pupil would only dilate freely in the direction up and inwards. In the opposite direction, that towards which the pupil was misplaced, there were some few tags of adhesion of the pupil—*posterior synechiæ*. There was no present iritis; the dilatability of the pupil also excluded the notion of its being associated with the existing keratitis. He had had at some time previously, no doubt, an iritis in this eye; and the synechiæ were its result; but, however distorted and changed in shape, I do not know or believe that the position of the pupil as a whole (circular and active, without mydriatics) may be changed by the iris inflammation. I do not know why an iritis, leaving adhesions, formed when the pupil was not very much contracted, at one part only of the circumference of the pupil, should not afterwards displace the pupil as a whole, and circularly towards the part which is adherent; but I have not known it occur; it then becomes at least oval in shape, if not more irregular. Perhaps it is only a question of the strength of the radiating fibres of the iris, in opposition to the sphincter pupillæ.

E. *Iris; Persistent Remains of Pupillary Membrane.*

12. A recent case of mine has been shown to the Ophthalmological Society, and is noted in the first volume of its Transactions, 1881, p. 217. But I have since had another such case. In the former case an exceedingly delicate, colourless, thread-like band crossed freely in front of the lens and iris so as to divide off the lower and inner quarter of the left pupillary space. It contrasted exceedingly well with another case of pupillary membrane exhibited by Mr. Power on the same day at the meeting of the same Society. For, in his case, the remains were broad, many, and considerable, pigmented, and all attached to the lens capsule. My second and last case is the following (Royal London Ophthalmic Hospital, November 3rd, 1881): George B——, aged fifteen, came for a defect of sight in his left eye. He had had inflamed eyes in infancy. The result of this no doubt, in the eye of which he complained, was that the cornea was mottled all over with nebulous opacities, and with this eye he could only make out with difficulty a rather large type. (For this opacity I ordered the yellow oxide of mercury and vaseline, to be applied within the palpebral aperture twice daily.) In the other, the left eye, the cornea was clear, and his vision normal; but in it he had the remains of pupillary membrane. In my first mentioned case, the band at the upper end was forked so that it had a double attachment above; so it was also in the present case, but that, instead of two little separate points of union with the front surface of the iris near together, they were far apart, almost with the longer, downward, band dividing the iris surface into segments of three equal parts, as to the points of their outer attachments, the longer band divided off the upper and outer third of the pupillary area. The two minor upper bands were very widely separated above, as I have said, so that they were, if the pupil was at all dilated, almost in a line with each other. All the three points of attachment to the front surface of the iris, the outer ends of the three bands, were at a distance, equally, of about one-quarter of the width of the surface of the iris from its inner circumference. The movements of the pupil, the extremest dilatation, &c. were not interfered with at all by these bands. They were evidently jointed, so to speak, at the junction of the inner ends of the three bands, in front of the pupillary area, and there also seemed to be a "giving," or pulling out, of the soft tissues of the front of the iris, in dilatation of the pupil. But the bands were also partly elastic, and so they allowed of extreme dilatation with-

out disfigurement of the outline of the pupil, and of extreme contraction also, which I observed to take place without any apparent slackening, no bulging or curving, of these cords, which, as at other times, remained as three converging straight lines. The lower and longer of these abnormal bands had most, if not all, the elasticity necessary for this condition during contraction of the pupil; for then the two shorter, upper bands were shortened, no doubt, but not much, and, as straight lines, approximated until they were at an acute angle. In the case I am now describing the bands were not either of them of a uniform thickness in their whole length; at their inner ends, to a definite extent, they were comparatively thick and pigmented (dark brown *uvea* coloured), the two upper bands to the extent in length of about 2 mm., and the lower band to a less extent. As this was the longer band, and only the thinner, grey, unpigmented, peripheral parts of either of the bands allowed, as to their length, of the movements of the pupil, it follows that this allowance depended almost entirely upon this long band. I judged that this was so, because I could observe no lengthening of the thicker, central, pigmented parts of the bands when the pupil was, even to the utmost, dilated, and also by the angular changes of the two upper bands to which I have alluded. Hence arose the necessity of the jointing, as I have called it. I may add that I have observed in another case, years ago, a similar stiffness in *a part of the length of* such bands as these, and an elasticity in other parts of the same. In all these, as in any persistent pupillary membrane cases, the diagnosis was quite clear and indubitable, because the outer ends of these bands were attached to the front surface of the iris, and not to any part of the pupillary margin. In the case I am now reporting there was a history and clear evidence, in the opposite eye, of a long-past eye-inflammation, but such bands as these are quite unlike any iritic synechiæ. These cases, and any others I have had in my own practice, were alike in that one eye only was the subject of the congenital defect, that the pupil, dilated or contracted, was quite circular, and that the bands were quite free from the lens.

(To be concluded.)

ON CALCULUS OF THE KIDNEY IN CHILDREN.

BY EUSTACE SMITH, M.D., F.R.C.P.,

PHYSICIAN TO H.M. THE KING OF THE BELGIANS, PHYSICIAN TO THE EAST LONDON CHILDREN'S HOSPITAL, AND TO THE VICTORIA PARK HOSPITAL FOR DISEASES OF THE CHEST.

STONE in the bladder is well known to be a far from uncommon affliction amongst the children of the poor, but a stone in the kidney is generally considered to be peculiar to a more advanced period of life. Children, however, do suffer from this complaint, and less rarely than might be supposed. The irritation of the stone may give rise to pain in the back, but more often the only symptom noticed is a copious discharge of blood with the urine. The passage of red sand from the bladder in children is not an uncommon occurrence, and, as a rule, little pathological significance is to be attached to it. Uric acid is very liable to be formed if food is taken largely in excess of the requirements of the system. It is not even necessary that the food be nitrogenous to produce this result, for, as Dr. Garrod has observed, it is a mistake to suppose that an animal diet must tend more to the formation of uric acid than a vegetable one. It must be remembered, however, that the presence of a deposit of lithic acid or its salts in the urine is no proof that any excess of acid is formed and secreted. The increase is often only apparent. When the urine is scanty from deficiency of water the uric acid may appear to be in excess. Again, great acidity of urine may cause a deposit of uric acid. The neutral lithates are more soluble than the acid lithates, and these than uric acid. Therefore, if very acid urine be secreted into the bladder when this already contains a neutral or alkaline urine, the acid abstracts the base from the neutral salts, and a deposit is formed at once. The uric acid appears in the urine in the form of crystalline grains, or, if very abundant, as a red sandy deposit. In infants and young children there appears to be a special tendency to uric-acid deposits, and these may be thrown down in the kidney itself before the urine has passed into the bladder. The so-called uric-acid infarctions of the kidney, forming yellowish-red streaks running in the directions of the pyramids, may be found after death in the youngest infants—in them, indeed, more frequently than in older children. These infarctions consist of amorphous urate of ammonia mixed with crystals of uric acid, and occupy the straight tubes of the pyramids. They do not, any more than the sandy deposits in the urine, indicate the existence of kidney disease. They are due to excessive feeding, or, in young babies, to the increased metamorphosis of tissue elements, which must take place after birth, in consequence of the newly inaugurated processes of digestion, respiration, and generation of heat. A deposit of crystals of uric acid may be formed at any part of the urinary apparatus. The urinary tubules often contain such collections. A particle of crystallised uric acid is deposited in the cortical part of the gland. It may remain in this spot, or may pass further down the urinary apparatus into the straight tubes or the pelvis of the kidney. In either case it is apt to become enlarged by successive additions to the original nucleus. Great irritation is often caused by the passage of these fragments, and even minute crystalline particles, if with sharp angles, may so scratch and wound the delicate membrane lining the fine tubules of the kidney and calices of the pyramids as to be a cause of hæmorrhage. In spite, however, of the frequency of sandy deposits, the urine in childhood does not, as often as might be expected, contain an admixture of blood. At least, an intimate admixture of blood with the urine, such as is known to be characteristic of renal hæmorrhage, is in the child comparatively rare. Besides uric-acid, oxalate of lime concretions are not uncommon in children. These are dependent upon the same causes as the preceding. According to Schenck, uric acid is converted by oxidation into oxaluric acid, and this is readily decomposed by both acids and alkalies, splitting up into oxalic acid and urea. The oxalic acid at once combines with the base of any lime salt which may be present, and is precipitated as the insoluble oxalate of lime. This process may take place in the urinary passages, and if crystals of oxalate of lime are found in warm urine before the fluid has had time to cool, it may be inferred that they have been formed inside the body, and we should think of the possibility of calculus. Besides uric-acid and oxalate of lime concretions, small calculi of the urates of ammonia and soda may be formed. Often the concretions are compound, and contain a nucleus of uric acid round which oxalate of lime or urate of ammonia has been deposited. If the concretion be encrusted with phosphates, it is a sign that irritation has been set up in the bladder or pelvis of the kidney. Some children have a greater tendency than others to the deposition of uric acid in the urinary passages. This tendency often runs in families, and is then commonly associated with the gouty constitution. The form of scrofula which is connected with a stout heavy build and much flabbiness of flesh is also said to be distinguished by the same tendency. In both of these cases there is no doubt an inclination to gastric disturbances and the generation of acid in the stomach. The actual deposition of uric-acid crystals in the form of sand and gravel is apt to be excited by excessive or unwholesome diet, especially of indulgence in the more fermentable articles of food. Thus, large quantities of farinaceous substances, particularly where the starch is imperfectly cooked, and of fruit and sweets, may give rise to the formation of acid in the digestive organs. Too close confinement to the house, especially in cold damp weather, may in some subjects load the urine with uric acid or its compounds. Indeed, any influence which interferes with the assimilative processes, such as fear, grief, and other depressing passions of the mind, over-fatigue of the body, temporary febrile ailments,—all these causes may determine a precipitation of uric acid in some part of the urinary apparatus.

The passage of the ordinary lithates is no more a cause of irritation in the young child than it is in the adult. A baby may pass urine thick and milky from the presence of urates without showing that he is sensible of any unusual sensation while voiding the contents of his bladder. When, however, free uric acid is discharged with the urine, we usually notice signs of discomfort. Water is passed more frequently and in smaller quantities. The child screams and strains during its passage, and, if old enough, complains of pain in the urethra. In these cases we shall often find red gritty matter on the infant's diaper, or red sand at the

bottom of the chamber-pan. Sometimes this irritation is a cause of wetting the bed at night, and therefore the water should always be examined for uric-acid crystals in cases of nocturnal incontinence of urine. While still in the kidney these concretions may give rise to few or even no symptoms. Sometimes the only sign of their presence is a copious admixture of blood with the urinary water. If the concretions are of some size the hæmorrhage may be accompanied by attacks of pain in the kidney. Hæmaturia in children, especially in infants, is usually to be attributed to this cause. The blood is intimately blended with the urine, and the mixture may have a deep red colour if the hæmorrhage be copious. The urine is acid, and deposits albumen on boiling, and often crystals of uric acid can be discovered with the abundant blood-corpuscles under the microscope.

A little girl, aged four years, the ninth child of healthy parents, was admitted into the East London Children's Hospital. No history of gout could be discovered in the family. Of the other children four had died—one from whooping-cough, the others of brain disease, nature unknown. The patient herself had been always a healthy child, with the exception of an attack of varicella in infancy, until twelve months before admission. At that time the mother had begun to notice that the child's water contained blood. At first this had only occurred about once a week; but the frequency of the hæmorrhage had gradually increased, and during the previous fortnight blood had been passed every day. The morning urine passed after the night's rest had, however, been always uncoloured until a week before admission; since that time the passage of blood had been continuous. At first the mother had noticed no other symptom, but after the hæmorrhage had continued for several months the patient had begun to complain of pain in the left side and back—at first only occasionally, but latterly several times in the day. The child cried bitterly, and attempted to relieve her distress by bending her body backwards across her mother's knee, with her head and legs hanging down.

On admission the girl was in good condition and had a florid complexion. Her weight was 22 lb. 10 oz. Her liver and spleen were of normal size, and the heart and lungs were healthy. The abdomen was unusually compressible. The aorta and iliac arteries could be felt pulsating on deep pressure, and both kidneys could be felt; they were not tender when touched, and seemed in every way normal. She passed urine more frequently than was natural, but there was no pain on micturition. Her skin was not harsh, it acted fairly well, and there was no sign of œdema. The urine was dark with blood; its specific gravity was 1024; there was a copious precipitate on boiling, and the microscope showed an abundance of blood-corpuscles in the sediment; after a few days stellate crystals of uric acid were also discovered.

The child was kept in bed, and was given a mixture containing carbonate of potash. The amount of blood in the urine gradually decreased, and in five days had quite disappeared. The urine then became perfectly normal, and ceased to contain albumen or blood-corpuscles. There were never any signs of casts, of purulent matter, or of mucus. No pain was noticed during her residence in the hospital, and she was soon discharged. About a month afterwards she was readmitted with the same symptoms, but they quickly disappeared, as before, with rest and alkalies. Her temperature was always normal.

This case is a good illustration of the symptoms produced in children by renal concretions in the kidney. It would be difficult to attribute the hæmaturia to any other cause. The significant fact that the bleeding occurred for the most part after exercise, and that until the amount of blood became excessive the water was clear in the morning when the child first rose from her bed, were strong arguments in favour of urinary concretions. The patient, besides, was in good condition and of a healthy appearance; and, although her kidneys could be felt on palpation, no increase in their size could be discovered. Lastly, crystals of uric acid were found in the sediment.

Examination of the urine in these cases often gives a negative result. Calculus may exist in the kidney without giving rise to symptoms of any kind. Between the attacks of hæmaturia the water may contain neither blood nor albumen; and unless sand or uric acid be actually passing, it may redden litmus paper but faintly. Sometimes the irritation produced by the presence of the calculus in the pelvis of the kidney may set up pyelitis. The stone then usually becomes enlarged by deposition of phosphatic salts upon its surface.

A child was admitted into the East London Children's Hospital suffering from tubercular meningitis. After death, which took place in two days' time, besides the morbid appearances usual in such cases, the left kidney was found to be extensively diseased. The organ was much enlarged, and contained about two ounces of creamy pus. In the interior it was hollowed into cavities, and its proper substance was almost replaced by caseous matter. A calculus of the size of a cherry-stone was impacted in the upper part of the ureter; above this the ureter and pelvis of the kidney were much dilated. In this case, no doubt, the stone had first, by the irritation it produced, set up pyelitis, and had then become impacted in the ureter, preventing the escape of the purulent matter.

When the concretion passes from the kidney into the ureter, and downwards into the bladder, there is always pain; but the child seems to suffer far less than an adult would do under similar circumstances. Sometimes an attack of abdominal pain in a child, attributed, as all such pain is apt to be, to abdominal derangement and colic, is followed by symptoms of stone in the bladder. It is, therefore, desirable in all cases where pain more than ordinarily severe appears to be suffered, to examine the state of the child's water, and inquire of the nurse whether sand or gravel has been seen at the bottom of the chamber-pan. If the stone becomes impacted in the ureter serious consequences may ensue. The irritation of the foreign body in this situation may set up inflammation and give rise to thickening and contraction immediately above the seat of the impediment. Higher up the ureter becomes greatly distended, and the pelvis of the kidney may suffer dilatation. In some cases the pressure of the secreted fluid, accumulating in the channels above the obstruction, may flatten out the kidney into a thin-walled cyst. This is one form of hydronephrosis. After the stone has entered the bladder the urgent symptoms excited by the presence of the calculus are familiar to everyone.

On account of the frequency with which uric-acid concretions are found in the urine of children, it is evident that the delicate membrane lining the tubules of the kidney is liable to be exposed to injury from the sharp edges of the crystalline masses, and consequently hæmorrhage in such cases is no matter for surprise. The wonder, indeed, is that it is not a more common symptom of uric-acid sand in young persons. That it is not so is probably due to the fact that the uric acid is commonly deposited from the urine in the bladder itself, and not at a higher point in the urinary apparatus. Sir Thomas Watson has recorded his opinion that many of the obscure cases of hæmaturia in the adult may be referred to renal calculi. In the case of children it may be laid down as a rule that renal hæmorrhage occurring in a child otherwise healthy, and accompanied by no symptoms or by hæmorrhage from other parts of the body, is in the majority of cases to be attributed to the irritation of crystalline masses in the tubules, calices, or pelvis of the kidney.

Not long ago I saw a little boy, aged ten months, who for six weeks had been passing water mixed largely with blood. Sometimes for a few days together the water would be clear, but the hæmaturia speedily returned. The specimen brought with the child was bright crimson in colour, and consisted of blood and urine intimately mixed together. It had a slightly acid reaction. Many blood-corpuscles were seen under the microscope, but no crystals of uric acid could be detected, although the medical attendant had found them occasionally in the sediment. The child had been brought up by hand and fed upon cow's milk and water. He had no teeth, could not stand, and showed signs of being under-nourished. The bowels were confined habitually; otherwise he seemed to suffer no discomfort, and was said never to be peevish or fretful. As the child was evidently insufficiently fed, I rearranged his diet, ordering one meal in the morning of oatmeal (one teaspoonful) with cow's milk; two meals of Nestles' food, and two or three meals of Mellin's food with cow's milk diluted with a third part of barley water. To regulate his bowels I prescribed a mixture containing the infusions of senna and gentian.

Some months afterwards I heard that the bleeding had continued for a few weeks longer, that the child had then seemed to be in great pain for a day and a night, but that after this the water had become clear, and had ever since been perfectly free from blood. The nutrition had begun to

improve immediately upon the change of diet. There can be little doubt that in this case the hæmaturia was the consequence of irritation of the kidney by a small angular concretion, and the pain spoken of was in all probability an attack of renal colic caused by the passage or attempted passage of the little calculus down the ureter. In cases such as this, the concretions must be looked for carefully in the urine passed at the end of the fit of colic. They are often no larger than a mustard-seed, or even a small pin's head.

As regards prognosis, the occasional appearance of free uric acid in the urine of infants and children is of no consequence whatever. The frequent passage of sandy particles is of greater moment, for in these cases we are justified in fearing the formation of a stone in the bladder. A mere passing hæmaturia should not have too much importance attached to it, for it is probable that a certain oozing of blood may occur in the kidney as a consequence of irritation from small crystalline masses which may be afterwards washed away. Repeated hæmorrhage from this source is, however, to be regarded with anxiety, and if there be signs of pain in the renal region preceding or accompanying the flow of blood, we have reason to fear the presence of a calculus, and further ill consequences are to be anticipated.

The frequent appearance of uric-acid crystals, or of sandy deposits, or even the habitual presence of urates in a child's water, should make us inquire very carefully as to the food he takes and the general conditions under which he is living. Such a child should live plainly. He should take meat once a day with vegetables, and a light custard or batter pudding. For his other meals he should have milk and bread-and-butter, with occasionally the yelk of an egg or a little bacon for his breakfast. Care should be taken that he does not overload his stomach, and the quantity of farinaceous food he eats should be duly proportioned to his power of digesting it. Sweet things should be given to the child with caution; and all cakes and biscuits between meals should be strictly forbidden. He should take exercise largely in the open air. His skin should be kept in good order by complete washing every day, and in the colder months he should be dressed from head to foot in some warm woollen material. Great attention should be paid to the ventilation of his bedroom, and in the winter he should be dressed and undressed in a well-warmed room. In the case of an infant vigilance should be exercised that the child does not take too large a quantity of food at one time, and that he is not burdened by too much farinaceous matter with his meals. Cleanliness and plenty of fresh air must be always insisted upon. For medicine, alkalies, such as the citrate of potash, should be given, and the treatment must be continued for several weeks. If hæmorrhage occur, perfect rest in bed must be enforced. These cases seldom require styptics, but, if thought advisable, a few grains of gallic acid may be given with dilute sulphuric acid two or three times a day. If from attacks of pain or frequent hæmorrhages it becomes evident that the child has a calculus of the kidney, citrate of potash or phosphate of soda should be given in sufficient doses to keep the urine slightly alkaline; and this treatment should be persevered with in the hope of dissolving the concretion, or at any rate of reducing its size sufficiently to enable it to escape by the ureter. If great irritation and pain are produced by the continued presence of the calculus, and the health and strength of the child seem to be seriously affected, the question of nephrotomy may be considered. In an attack of nephritic colic, the child should be kept under the influence of morphia, and hot fomentations must be applied to the abdomen.

CASE OF HYDROCELE OF THE NECK.[1]

By JAMES WHITSON, M.D.,
EXTRA DISPENSARY SURGEON, GLASGOW ROYAL INFIRMARY.

CYSTS of the neck are always interesting and instructive to the surgeon. Interesting because they are somewhat uncommon, and instructive because their treatment gives scope for ingenuity and skill. From their proximity to important bloodvessels and nerves, care in operating and in subsequent treatment requires to be exercised, particularly in those cases where the cervical fascia is involved. The ordinary hydrocele of the neck is generally single, and the most common situation is below the sterno-mastoid muscle, which in consequence is thinned out, giving the appearance of a wavy line. It usually contains serous fluid, and varies much in size. We are told by Erichsen that the largest he has seen was the size of an orange. A case is reported in Bryant's Surgery, which assumed much larger proportions, and one similar to this having come under my care, I beg to give the following particulars.

Agnes H——, aged seven, was admitted on Aug. 8th, 1881, to Ward 22 of the Royal Infirmary, suffering from a well-marked hydrocele on the right side of her neck. The patient's father stated that it commenced when she was

five months old, and had continued to increase in size ever since, but most markedly during the last three months. It had never caused any uneasiness or inconvenience except from its size, or from pressure upon neighbouring structures. The cervical vertebræ were much more plainly felt on the right side than is usual, in consequence of the pressure of the hydrocele on the parts in its immediate vicinity. The head for the same reason was carried slightly to the left side. The hydrocele had an oblique depression, which almost divided it into two, and corresponded with the course of the sterno-mastoid muscle. It was resolved to evacuate the contents of the cyst by means of the aspirator,

and see what the effect would be, combined with steady pressure. This was accordingly done on Aug. 14th, when thirteen ounces of a highly albuminous fluid were withdrawn. The wound was painted with collodion, and firm pressure over the seat of the hydrocele was maintained by means of pads of lint and a bandage. Treatment by compression was carried out for two or three weeks, but at the end of that time it became evident that the cyst was slowly refilling. It was determined to wait until this was completely accomplished, and then to adopt a more vigorous method of treatment. By the middle of November the cyst

[1] Read before the Med.-Chir. Society of Glasgow, Feb. 3rd, 1882.

was found to be as large as before, and on the 18th the patient was put under chloroform, and an incision made into it under antiseptic precautions. The fluid having been evacuated, a brush dipped in tincture of iodine (Edin. Phar.) was then applied to the inner surfaces of the cyst walls, care being taken to go well into the corners. A couple of decalcified drainage-tubes threaded with hair were passed into the cavity, and retained in place by means of catgut sutures. The usual antiseptic dressings of protective plaster and gauze were applied over the wound, and kept in position by gauze bandages. An elastic bandage was put on over all, in order to prevent the dressings becoming disarranged. Next day the wound was redressed, and found to be looking well. There was a slight discharge of serous fluid. A week later the decalcified drainage-tubes were found to be flattened, and the skin of the neck was assuming its normal appearance. Three weeks afterwards a little exuberant granulation round the edges of the wound was snipped off with a pair of scissors. Dressings of boracic lint were substituted for the protective plaster and gauze, and within five weeks of the operation the wound had healed. With the exception of the scar of incision no trace of the hydrocele remains. The head is still carried slightly to the left side, but this will probably improve with time. The cervical vertebræ are by no means so distinctly felt as at first. The accompanying woodcuts give an accurate representation of the case before and after treatment.

NOTES ON A CASE OF

SUDDEN DEATH FROM ASPHYXIA IN A PHTHISICAL BOY.

BY W. BARRETT ROUÉ, M.B., M.S.,
PHYSICIAN TO THE BRISTOL HOSPITAL FOR SICK CHILDREN.

ON May 3rd, 1881, I was called to see a wretched, neglected-looking boy, aged eleven years. The history was that of a cold resulting in some chest affection, for which he had had no medical advice. A constant cough and pain in the chest had been present for five months.

On my first visit I found him sitting up in bed, breathing rather rapidly, but not seeming much distressed, and in the act of expectorating much purulent sputum into a receptacle already nearly full. On physical examination there appeared to be no flattening or falling in of the chest on either side, but the respiration was shallow. There was marked dulness at the right apex both in front and behind, and large moist sounds were heard over the upper portion of the same lung, accompanied by small crepitations. There was increased vocal resonance all over the remainder of the right lung. On the left side there was exaggerated breathing, which I considered to be merely compensatory, with slightly prolonged expiration. Otherwise the lung seemed healthy.

The boy was treated for his cough, and an attempt was made to improve his general condition by the administration of cod-liver oil, milk, and beef-tea. In spite of this treatment, he steadily decreased in weight, as the following will show: May 3rd, weight 51½ lb.; 10th, 50 lb.; 17th, 48lb. The temperature varied from 100° to 104°, usually highest at night-time. From this I considered the prognosis to be unfavourable, but did not by any means apprehend a very rapid or a sudden termination to the case.

On May 19th, whilst sitting up in bed, and without any severe cough, blood mixed with air began to well from his nose and mouth, and in about three or four minutes he was dead—as it appeared, simply from asphyxia, the trachea and bronchi being full of blood, which the boy was unable to expel.

Post-mortem examination.—Body much emaciated; face mottled blue and red. Heart healthy; right side gorged with thick black blood; left side empty. The right lung was solidified throughout, except a small portion of the extreme apex, and composed of degenerated cheesy-looking material. There was a large irregular cavity, about the size of a goose's egg or larger, in the lower part of the upper lobe, extending for a considerable distance into the lobe beneath. This cavity was situated more towards the posterior than the anterior aspect of the chest—indeed, there was scarcely any lung-tissue left beneath the pleura in the former situation. The cavity was full of soft recent blood-clot, which passed into the communicating bronchus and upwards towards the trachea. On removing the blood-clot, an artery about the size of a crowquill was found severed, and the ends hanging down against the walls of the cavity, one on either side. This vessel, previous to its rupture, had evidently passed right across the cavity. The left lung was emphysematous, the air-cells and bronchial tubes were full of blood, and a clot passed a considerable distance up the left large bronchus; otherwise the lung was healthy.

Remarks.—Up to the moment of the occurrence of the hæmorrhage I think we have a fairly clear case of a condition which, for want of a better name, I will call "pneumonic phthisis." The little patient had probably suffered from an attack of pneumonia in the right lung, the products of which failing to be absorbed, had broken down, and then gradual disintegration had caused the cavity. The important question is, What was the immediate cause of death? Two causes only, I think, are worthy of consideration—viz., syncope from loss of blood, and asphyxia. There is certainly a third possible cause in shock; but the difficulties of arriving at any reliable conclusions as to this condition in children when the physical signs of organic mischief are so decided as in this case, justify the little notice I have taken of shock as an agent of death. With regard, then, to syncope from loss of blood, the post-mortem evidence is certainly against it. In the first place the condition of the body strikes us: the face was mottled and of a purple colour; in death from syncope it is usually very pale. In the second place the right side of the heart was gorged with blood; in death from syncope all the cavities are usually empty. Really the patient lost very little blood considering the rapidity of his death. Upon consideration, then, asphyxia seems to be the immediate cause of death suggested by the post-mortem examination, for the following reasons—

1st. The right side of the heart was gorged while the left was empty.

2nd. The large and smaller bronchi in both lungs, and even the air-cells in the sound lung, were filled with blood, so as effectually to cut off all communication between the air and the air-cells.

3rd. The face bore the mottled and purple hue so well known in cases of death from suffocation.

TUMOUR OF ANTERIOR SURFACE OF THIGH SITUATED IN SCARPA'S TRIANGLE.

THIRTEEN YEARS' GROWTH; SUCCESSFUL REMOVAL.

BY JOHN TUDOR, M.R.C.S. ENG.,
SURGEON, DORSET COUNTY HOSPITAL.

L. A. S——, domestic servant, aged twenty-five, admitted into hospital on October 28th, 1880. She is a well-nourished young woman, with light hair and complexion, and of a decidedly healthy appearance. About thirteen years ago she first noticed a small tumour about the size of a bean in the right groin. She does not seem to have taken much further notice of it until about nine years subsequently, at which time it had increased to about the size of a hen's egg. She then placed herself under the care of a medical man, who applied iodine and other remedies, but without any result in checking the growth, which gradually increased in bulk up to the date of her admission into the hospital. For some time previously to this she had been suffering from shooting pains in the limb, and had also experienced inconvenience in walking up and down stairs. When the patient was first brought under my notice there was a tumour occupying the anterior superior part of the thigh, corresponding to Scarpa's triangle in outline, about the size of a small cocoa-nut, with an even surface, and symmetrical in shape. Upon manipulation, its structure seemed to be of a mixed character, chiefly solid, but in parts yielding and elastic. It was pretty freely movable, and the fingers could be passed under the edge of it around the margin. On the under surface the attachments were rather firm, but the muscles were apparently free. Taking all the circumstances into consideration, I judged that I had to deal with a fibro-lipoma, and not a simple fibroid, as was at first supposed and represented to me.

On November 2nd the tumour was removed by an incision nine or ten inches long, commencing a Poupart's ligament, about an inch outside the femoral artery, and

carried down the centre of the growth to the lower margin. The upper portion of the tumour was freed, and the fingers passed behind it, and, chiefly by tearing, but with an occasional careful use of the knife, directed towards the base of the tumour, it was quickly removed. The deep layers of the fascia lata and the sheath of the sartorius were extensively detached, being incorporated in the capsule of the growth. Two arteries which bled freely were tied, and the surface of the wound washed over with oil of turpentine to check oozing. The parts being brought together were covered with lint, and oil of turpentine with cotton-wool. On the 4th the dressings were removed, and the wound was found to have healed favourably. On the 6th the sutures were taken out. There was some tumefaction in the surrounding parts, and the patient complained of pain in the calf of the leg, which continued, off and on, for some weeks. The ligatures did not separate for an unusual time; the first on December 3rd, the second on February 14th, being in the one instance a month, and in the second three months after application, although considerable traction was frequently made upon them. During this period the patient suffered from pain and swelling behind and surrounding the cicatrix, and also from inflammation and enlargement of the inguinal glands. These symptoms caused me some apprehension, tending, as they seemed to do, to the probable return of the disease, as we had now discovered that the tumour was a sarcomatous one, being largely composed of small round cells. However, soon after the separation of the ligatures the swelling and pain disappeared and the patient was discharged apparently quite well. She was carefully examined two months after leaving the hospital, when her general condition, as well as the seat of operation, were in a satisfactory condition. The ligatures, which were applied hastily in consequence of free bleeding, enclosed pieces of fascia, which accounted for their prolonged detention *in situ*.

The tumour measured twelve inches by nine inches in circumference, and weighed twelve ounces. The capsule consisted of dense cellular tissue, and was about the sixth of an inch in thickness. Upon section the growth seemed to consist of dense fibroid tissue, intersected by a firm, semi-gelatinous material, of a yellowish-green shiny colour, from which exuded a tenacious mucoid matter, whilst here and there were deposits of a calcareous substance. The slowness of the growth in the early period seemed to favour the opinion that the tumour was of a simple character, and that subsequently it became transformed from a fibro-lipoma into what it has been demonstrated to be, a round-celled sarcoma. For a most careful examination of the tumour I am indebted to my friend Mr. Nunn, of the Middlesex Hospital, who also procured for me some beautifully prepared slides, demonstrating the development.

A Mirror
OF
HOSPITAL PRACTICE,
BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

LONDON HOSPITAL.

PRIMARY DYSMENORRHŒA; OS EXTERNUM ADMITTING NO. 11 BOUGIE; DIVISION OF VAGINAL PORTION BILATERALLY; RELIEF TO DYSMENORRHŒA FOR AT LEAST TWELVE MONTHS.

(Under the care of Dr. HERMAN.)

FOR the following notes we are indebted to Mr. J. Garrett.

E. R——, aged twenty-four, married, was admitted on December 22nd, 1876. No relative had been known to have any uterine trouble. She had herself always been in comfortable circumstances, and had had no previous illness except an attack of erysipelas two years before. She first menstruated at eighteen, and had been regular every four weeks since, the flow being scanty, and lasting three days. Menstruation was from the beginning attended with great pain, which used to come on three days before the period reached its height just before the flow, and last till the end; a constant, dragging pain, which was felt chiefly in the left iliac region, down the thighs, the left the worse, and in the left breast, not in the back. It was not paroxysmal. She was in the habit of taking gin to ease it, and found it do so. The less the flow the worse the pain. For five or six months before admission the flow had been getting less and the pain greater, and there was a good deal of leucorrhœa a week before and a week after the period. She was married at the age of twenty, but had had no sign of pregnancy. There had been dyspareunia for the last twelve months. She had been getting pale for about two years. For the last twelve months, never before, she had suffered from headaches, coming on almost every morning, and lasting three or four hours, frontal accompanied with amblyopia and with nausea. For the last six months she had been troubled with interscapular pain, coming on about half an hour after food, and lasting about two hours. Appetite good; bowels regular. She was of middle stature, well built and well nourished, but very anæmic. On abdominal palpation, there was tenderness over the region of the left ovary. Per vaginam, the uterus was found to be in the normal position, slightly anteflexed, rather small, its cavity only measuring two inches and a quarter in length. The vaginal portion was about half an inch long, conical in shape. The external os admitted a No. 11 urethral bougie, the internal os a No. 7. What seemed to be the right ovary could be felt per vaginam, but the left one could not be reached. The vaginal and uterine mucous membrane were healthy. There were no signs of disease in any other part of the body.

On Dec. 27th the vaginal portion was divided bilaterally with Küchenmeister's scissors. There was very little hæmorrhage. A strip of lint soaked in carbolised oil was put into the cervical canal; this was removed the following day.

Jan. 12th, 1877. — No pyrexia or other bad symptom followed the operation. She began to menstruate on the evening of Jan. 9th, it being then her right period. She had no pain at all, and the flow was more copious than it had been at any period during the previous twelve months. On the 13th she was sent to Mrs. Gladstone's convalescent home at Woodford.

The patient was seen on April 28th. She had menstruated three times since leaving the hospital; had had no pain to speak of, and the quantity was more than formerly. The sick headaches had only troubled her two or three times, and there was no dyspareunia.

On March 21st, 1879, in answer to an inquiry, she attended at the hospital, and the following notes were made. "She had had no pain with menstruation since the operation until two months ago. At these two periods the pain had come on about a fortnight before, and lasted until one or two days after the flow. It was felt in both thighs, especially in the right; was worse at night; better when walking about. No abdominal pain. Slight pain in the lumbar spine during the flow. Pain in the breasts came on a week before the flow, and ceased when the flow appeared. Quantity of flow less the last two or three months. For twelve months had been losing flesh. Appetite had been bad for three months, and she had been getting 'nervous.'" Was now menstruating, therefore an examination was not made.

The patient did not again attend at the hospital, and no further information could be obtained about her.

NEUROTIC INHERITANCE; ACQUIRED DYSMENORRHŒA; NERVOUS SYMPTOMS; OS EXTERNUM ADMITTING NO. 10 BOUGIE; DIVISION OF VAGINAL PORTION; RELIEF TO DYSMENORRHŒA FOR AT LEAST FOUR YEARS; NO BENEFIT TO NERVOUS SYMPTOMS.

(Under the care of Dr. HERMAN.)

R. B——, aged twenty-five, married, was admitted on Feb. 14th, 1877. She stated in reference to her history that her father, brothers, and paternal grandfather all had fits; that her mother suffered from hysteria and neuralgia; that her sister had had rheumatic fever, and had diseased heart; and that all the family were subject to sick headaches, and were very nervous. Character of menstruation in female relatives was not known. Two sisters were married; both fertile. The patient was born in the country and was much in the open air when young; she was never in want, and was a servant from the age of sixteen till her marriage. She first menstruated at the age of thirteen. The flow was wont

to return at intervals of from two to three weeks; was copious, lasting three or four days; clots were passed, but no pieces of skin. It was not accompanied with much pain until five years ago. During the twelve months prior to admission the pain had been getting slightly better, and the amount of the flow had been less. The pain at the time of admission came on two days before, and lasted till the end of the flow, being at its height just before the flow. It was felt in the lower part of the abdomen, worse on the left side, in the breasts, and at the bottom of the back, and the legs ached. It was not a constant pain, but intermittent. It was sometimes, but not always, bad enough to lay her up. For four or five years she had had a leucorrhœal disease. She thought she had all her life been subject to pain in the left iliac region and in the breasts. Her memory was very bad, and she could not give a clear account of the onset of her symptoms. She had been married two years, but had never had any sign of pregnancy. For ten years she had been subject to rheumatic pains in her legs, but these have never been bad enough to lay her up. For five years she had suffered from hysterical seizures, usually coming on at the menstrual period, and if "upset" about anything. In these attacks she shook very much, and cried—did not fall down and lose her senses. For four years she had had, on and off, "neuralgia" in the right side of her face. She was subject to sick headaches, which came on about once in three months, and lasted a day. The pain was frontal, and was accompanied with nausea. During the attacks of headache she often fancied that she saw things which had no real existence—e.g., men coming in at the door; saw colours before her eyes; had noises in the ears, the right the worse. She was subject to vertigo upon any excitement, which lasted until she got "quieted down"; things seeming to go round from right to left. For four or five years the bowels had been habitually confined, and for twelve months there had occasionally been pain accompanying defecation. For three or four months there had been slight scalding pain on micturition. The appetite had been failing for the last three months, and she had been troubled with interscapular pain after food, and with flatulence. For the same time she had been getting "nervous," and her memory had been getting bad. She thought she had been getting thin lately. Her home and domestic circumstances were quite comfortable. She was a nervous-looking woman. There were no physical signs of disease in any part of the body except the pelvis. Uterus in normal position and of natural size, except that the vaginal portion was rather thick. The os externum admitted No. 10 bougie, but not a larger one. There was no tenderness in either ovarian region, either per hypogastrium, per vaginam, or per rectum.

On Feb. 22nd the vaginal portion was divided bilaterally with Küchenmeister's scissors, and a strip of lint, soaked in carbolised oil, was put into the cervical canal. No pyrexia or other bad symptom followed the operation. She left the hospital, at her own wish, on March 9th. She menstruated from March 14th to the 18th without any pain, the quantity of the flow being the same as usual.

On Oct. 17th it was ascertained that she had menstruated regularly every month since March, with either no pain at all or very slight pain. She had complained much of soreness of the vulva and a bearing-down feeling, of a burning pain in the stomach, and of feeling weak and nervous. The headaches much the same. Much depression of spirits; said she had sometimes thought she would go out of her mind.

On Jan. 6th, 1881, in answer to an inquiry, the patient writes:—"I am very much better. . . . I suffer very little pain at the monthly periods. . . . I still suffer very much with my head, if not for that I am better than I have been for some years. I have never had any sign of pregnancy."

Remarks by Dr. HERMAN.—These cases illustrate the fact that there are instances of painful menstruation in which division of the vaginal portion of the cervix will be followed by long-continued relief. It has been stated recently in THE LANCET and elsewhere that this operation was now very seldom performed, and indeed had almost become disused; and it may be inferred from such a state of opinion that it has probably been performed in many cases for which it was unsuitable, and in which consequently benefit did not follow; and that sufficiently exact criteria for the selection of the cases in which this operation is called for have not yet been laid down. Such criteria can only be obtained by the comparison of fully reported cases which have been watched for a long time; and as a contribution to such data these cases are published. They show that absolute smallness of the cervical canal is not the essential condition upon which benefit following incision depends: for in one of these the os externum admitted No. 11 bougie, in the other No. 10, and yet enlargement of the canal by incision removed the menstrual pain. In the second case the dysmenorrhœa was accompanied by nervous symptoms such as have been often described as reflex results of this affection; but the history shows that the menstrual disorder was at most the exciting cause only, that the patient inherited a strong tendency to nervous disease, and therefore that similar nervous symptoms would probably have complicated any kind of local disease which caused pain, and made the patient anxious. It is probable that in most cases in which prominent nervous symtoms accompany slight uterine disease the local malady is only a minor factor in their production, the chief element being an inherited or acquired state of nervous system which does not depend upon the uterine disease, and is not removed by curing it, even though the nervous symptoms may sometimes temporarily disappear.

SOUTH DEVON HOSPITAL, PLYMOUTH.

CASE OF POISONING BY HEMLOCK (ŒNANTHE CROCATA); RECOVERY.

FOR the following notes we are indebted to Mr. GODFREY CARTER, house-surgeon.

D. C——, aged thirty, a Greek sailor, was admitted into hospital on Jan. 13th, 1881, semi-comatose from accidental poisoning. On the previous day, about noon, he and two other sailors were ashore from their ship in the Sound. During a walk near the headlands overlooking the bay they partook of what they considered to be "wild celery," of which a considerable quantity is found in the immediate neighbourhood of Plymouth and Devonport. This vegetable, though somewhat closely resembling celery, is well known as the most poisonous form of hemlock, the hemlock water dropwort. The man D. C—— ate part of the root, and some of the stem, of the plant. In due course he reached his ship. Two hours after partaking of the "celery" he ate a full meal, feeling perfectly well. Within fifteen minutes of this time he suddenly and violently vomited. The whole contents of the stomach were evacuated. In five minutes he was completely unconscious, and had muscular twitchings about the limbs and face. There was a copious flow of a thick tenacious mucus from the mouth, which hung about the lips and clothing in viscid strings. Coma profound for twelve hours.

Twenty-four hours after the poisoning he was admitted into hospital, apparently semi-comatose from drink. He entered the casualty room supported on each side, and dragging his legs after him. He had feeble control over them. Placed in a chair he went to sleep, with his head hung on his left shoulder and his arms by his side. The extremities were cold, but there was general free sweating. He could be roused with difficulty, when he muttered something in an unknown tongue. There were no spasms. The pupils were dilated and sluggish. The respiration only 14 per minute; not full. No stertor.

Twelve hours after admission the skin was warm, and sweating very freely. Temperature normal. He was in a continuous sleep, from which he was easily roused, and then he drank greedily. The tongue was dry and coated. Respiration still 14. Salivation ceased.

On the following day he was quite conscious; had great thirst, and signified by signs that he felt swimming in the head. Urine, sp. gr. 1030, scanty, albuminous. Bowels moved moderately by castor oil. Pulse throughout was about 80; good. On the next day, Jan. 15th, he was discharged well. Urine free from albumen.

Remarks.—The difficulty in this case was in not being able to procure an interpreter until after the symptoms had passed off, and it was by this means that a careful account was obtained of what happened up to the time of admission. The two other men only partook slightly of one of the stems of the plant, and escaped with some uncomfortable feelings of deadness and staggering about the legs. It is interesting to note that three cases were reported from Plymouth in THE LANCET twelve months ago by Dr. Bampton, when two recovered and one died.

GOCULDAS TEJPAL HOSPITAL, BOMBAY.

CASES OF LITHOTOMY.

(Under the care of Surgeon-Major T. CODY.)

THE following notes relate some of the unforeseen difficulties and complications met with in performing the operation of lithotomy.

CASE 1. *Removal of four calculi and a large quantity of gravel; recovery.*—B. S——, a Hindoo lad, aged eleven years, had been suffering, according to his parents' account, for over two years. He had a constant burning pain in the region of the bladder; much difficulty in passing urine, which was cloudy and fetid, and contained pus. The lad constantly pulled at the penis, from which the prepuce had become long and pendulous, being also slightly œdematous. He was very much emaciated, had a staring, excited appearance, and screamed out when anyone approached him. On examination of the bladder with a sound a muffled note was heard; but the touch gave indications of a large calculus. Chloroform was given, and the lateral operation was performed. On entering the bladder a stone was felt immediately in the lips of the wound. This stone was removed by the forceps without any difficulty, and when the finger was again introduced another stone was felt, which was removed in the same way. After the removal the finger was again introduced, when a small stone was felt lying in what seemed a regular sand-bed; this was removed by the scoop, together with a quantity of gravel. A second and a third scoopful of the gravel were then removed, and the bladder was washed out with warm carbolised water (1 in 40). After the washing the finger was again introduced, when a fourth stone was felt high up in the bladder, which was removed by the forceps without difficulty. The bladder was again washed out, and the operation completed. Four calculi were thus removed, weighing in the aggregate one ounce, three drachms, and twenty grains, besides three scoopfuls of sand. Three of the stones were phosphatic in character, as was also the débris removed by the scoop, while the fourth was composed of uric acid. They were all rough on the surface, and presented no facets, though they could be easily placed in apposition to form one mass. The boy recovered without a bad symptom, and was taken away five weeks after the operation quite healthy and strong, with the wound completely healed.

CASE 2. *Removal of mulberry calculus, and three fibrous tumours; recovery.*—P. G——, a native Christian, aged fifty-four years, was admitted with the usual symptoms of stone, from which he had been suffering for a year previous to admission. The sound struck the stone immediately on being introduced, and could be moved freely round and round it, and no indications were given by it of what was subsequently discovered.

The patient having been placed in position the lateral operation was performed, and the bladder entered without any difficulty. On introducing the finger the stone could not be felt for some little time, but at last it was found embedded in what appeared to be folds of mucous membrane. After a little manipulation it was caught by the forceps and extracted. On introducing the finger again into the bladder a tumour was felt, which was movable, and by hooking the finger round it it was found to be attached by a string-like pedicle, which gave way on slight traction. The force used brought it to the edge of the wound, when it was extracted by the scoop. A further exploration showed where two other tumours, about half the size of the first, which was as large as a walnut, were lodged, and they were hooked out by the finger. The bladder was now washed out and the patient removed to bed. The stone weighed five drachms, and was of the mulberry character. The tumours were hard to the feel and polished and glistening on the surface. They consisted of hard fibrous bands, in the meshes of which a consolidated fatty substance was lodged. This case progressed without a bad symptom, and the patient left the hospital perfectly well five weeks after the operation.

CASE 3. *Removal of a calculus weighing six ounces and three drachms; death.*—B. P——, a Maharatta cultivator, aged twenty-seven, had suffered for five years before admission from pain and weight in the region of the bladder with difficulty of micturition, the urine latterly dribbling away from him. He was very weak and emaciated, and had the haggard, worn look of a man suffering from the constant pain of some organic lesion. On introducing the sound the calculus was immediately struck, and it gave a sensation of there being more than one stone, the point seeming to glide from one to the other. After some preparation the lateral operation was performed. On entering the bladder the edge of the scalpel struck the stone, which grated against it as the incision was prolonged. On passing the finger the stone was found to be very large, and it was remarked how easily the parts yielded as the finger was passed round for the purpose of dilating the wound. The end of the stone could be seen in the lips of the wound, and a short forceps was passed over it grasping it high up. It was then slowly and gently extracted, the extraction being accompanied by a strong expulsive force resembling in character the action of the uterus. The weight was six ounces and three drachms; the length was three inches, and the circumference at the widest part was five inches and three-quarters. It was of an irregular oval in shape, and had a projection. The lower portion of the body and the projecting portion were pale-grey in colour, very hard, containing on the surface numerous small, brilliant crystals, while the other portion of the body was dark-red, rough, and tuberculated. This latter appearance was only superficial, as below this layer, which was oxalate of lime, the characters of the triple phosphate were again apparent. The stone lay in the bladder with the constricted portion projecting into the neck, the short and narrow border being in front and the long, thicker one behind. There was no vessel spouting, but there was a good deal of oozing, which did not cease after repeatedly washing out the bladder. A bell-tent catheter was then introduced, and the wound was plugged with carded oakum, which arrested the oozing in a very short time, and in the course of an hour or a little more the urine was passing quite clear through the catheter. The day after the operation the plug was withdrawn, but the oozing setting in again it was replugged and left till next day, when both plug and catheter were withdrawn. The wound looked perfectly clean and healthy, and the urine flowed freely from it. The man himself seemed to brighten up considerably after the operation, and for some eight or nine days everything looked most hopeful, but at this time a change set in, and, without complaining of any pain or uneasiness, he began to lose ground and languish till the eighteen day after the operation, when he died. No post-mortem could be held as the friends objected, but it was suspected that the kidneys were extensively diseased. The wound looked quite healthy and promising up to the last.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

The Surgical Uses of Kangaroo Tendons.—Two Cases of Unreduced, and Two Cases of Reduced, Dislocation of the Hip.

THE ordinary meeting of this Society was held on the 14th inst., Dr. A. W. Barclay, President, in the chair. At the commencement of the proceedings a letter was read from Mr. Charles Hawkins, addressed to the President, and presenting to the Society the minutes and transactions of a Medical Society founded by John Hunter in 1783, before the Royal Medical and Chirurgical Society was established (see p. 283). Time did not allow of an adequate discussion of the chief paper of the evening, that dealing with the subject of Dorsal Dislocations of the Hip, by Mr. H. Morris, the only speaker being Mr. Eve, who on a previous occasion had read a paper in controversion of Mr. Morris's views.

A paper was read on the Surgical Uses of Kangaroo Tendons, by T. M. GIRDLESTONE, F.R.C.S., Lecturer on Surgery in the University of Melbourne, Victoria (communicated by Thomas Smith, F.R.C.S.). The author stated his belief that for tying large vessels in their continuity, the long even tendons from the tail of the kangaroo were as strong as the silk ligature, caused no ulceration in the coats of the vessel, and had all the valuable qualities of catgut, without its defects. The tendons also make excellent sutures, resisting the effects of purulent discharges for a long period. They have been used in Melbourne in place of silk or gut since 1877, when they were first brought before the notice

of the Medical Society of Victoria. In their use in the Melbourne Hospital in the deligation of main arteries, the inner coats of a vein could be divided or not, and the ends of the ligature cut short off. A reef knot does not slip or become loose. Where there is no suppuration the tendon coalesces with the tissues, and in suppurating wounds, though softened, they are found still to hold together at the end of eight days. The tendons were previously immersed for some weeks in carbolic oil, and entire tendons only were used. They have been employed in ovariotomy and in vesico-vaginal fistula, and held till union took place. In plastic operations—hernia and varicocele—the tissues have readily healed over them. A medium-sized tendon is so strong that it is difficult to break it with one's hands, and it is uniformly strong in its entire length of from twelve to eighteen inches. Tendons can be hardened for use as sutures by immersion in a half per cent. solution of chromic acid, after which they can be also used as drains for wounds. In their preparation they should not be removed from the tail *en masse*, but one at a time and without force, as if split longitudinally they cannot be relied on, and should not be used. Every diameter that is required is attainable, so that there is no occasion for splitting, neither should two or more tendons be twisted together, as it destroys their flattened form. On removal from the recently killed animal they should be cleansed in water, and afterwards in a carbolic-acid solution, and then dried, and can be so preserved, or in a 5 per cent. carbolic oil, as most convenient, to be again steeped in a watery solution of carbolic acid before use. The tendons can easily be obtained.—Mr. T. SMITH said that Mr. Girdlestone had sent the paper and specimens of the tendons to the Society at his suggestion. He (Mr. Smith) had used them as sutures in ruptured perineum, and found that without further trouble they had been removed. He had also used them for ligature of several large arteries, including three femorals. On one occasion a frayed ligature broke through. The superiority of the kangaroo tendon over catgut is probably due to its being a *natural* ligature, catgut yielding to mere soakage in animal fluids, the tendon only to absorption. He had used it in a case of gastrostomy, but at the end of ten days death occurred, chiefly by the stomach falling away from the abdominal wall, owing to rapid absorption of the ligature.—Mr. GODLEE thought it was to be regretted that there were no specimens of these ligatures in carbolised oil, for they seemed to be absorbed rather quickly, unless specially prepared. Mr. Lister lately used them as sutures for a small wound after removal of a tumour of the breast. At the end of a week the sutures were much softened. Such a ligature would be unsafe to apply to large arteries, and would lead sometimes to failures similar to those recorded of the catgut ligature. Catgut itself is absorbed very rapidly if not prepared, although it is very strong. For this reason he would warn surgeons against the use of the tendon ligature until it had been prepared by immersion in carbolised oil.—Mr. DENT last session read a paper on a case in which both a catgut and a tendon ligature had been applied to the same vessel by Mr. Pollock. Ten days later the catgut (unprepared) had disappeared, but the tendon remained. He considered the tendon to be very strong and durable, and to resist the action of the tissues for a long time. If the tendon be too hard the same accident may happen as occurs with over-prepared catgut; he had seen it actually cut itself through at the knot. At his suggestion, a round twisted tendon ligature had been prepared, which retained a remarkable elasticity even when dry. He believed that tendon was the best form of animal ligature known, and would not hesitate to apply it to any artery in its continuity. A single knot would hold, as in the case he had described.—Dr. HEYWOOD SMITH thought Mr. Godlee's remarks pointed to these ligatures being unfitted for plastic operations, where sutures had to be retained some time. He asked Mr. Smith if he had used these ligatures in ovariotomy. Had they any advantage over pure silkworm ligature?—Mr. BARWELL thought the tendon likely to be a good ligature; but he differed from Mr. Godlee as to the need of preparation, and his own experiments led him to think that a mere keeping in fluid—e.g., a little carbolised water—was sufficient, whereas soaking in carbolised oil deteriorates it, and makes it uncertain as to strength. In the ox aorta ligature he uses no preparation, and he placed greater reliance on it in consequence. There is now a large number of animal ligatures—e.g., catgut, whale tendon, aorta, &c. Professor White of Philadelphia, who had used ox aorta, was now using the sciatic nerve of the calf, which answered well experimentally. In fact, any animal substance, if perfectly fresh, suffices, providing its strength and reliability are all-sufficient.—Mr. F. S. EDWARDS said that he had tied the femoral artery with the tendon ligature in a case of popliteal aneurism, when treatment with Esmarch's bandage had twice failed. The artery was ligatured in two places, and the case did well, healing being slightly delayed.—Mr. HOLMES had hoped to hear something of the effect of these ligatures, the fact of their use being long known. Mr. Stirling introduced them at St. George's Hospital some years ago. It would add to the value of the paper if Mr. T. Smith would say to what conclusion his experience had led him. As a suture the tendons were no better than carbolised catgut; but he thought that catgut was used with more confidence if unprepared than if prepared. Mr. Barwell's ligature of ox aorta was also admirable as a ligature for an artery in continuity. He was disappointed that Mr. Girdlestone did not put his experience on record, or state whether any opportunities arose for examining the vessels tied.—Mr. SMITH, in reply, trusted that many years would pass before the opportunities for dissection would arise. None of his cases had afforded him that opportunity, and without experiments on animals the fate of the ligature could not be decided. He gathered from Mr. Girdlestone that he also had had no such opportunity. Mr. Smith showed a specimen of whale tendon. In reply to Dr. H. Smith, he said he had never used the kangaroo ligature for ovariotomy; it did not seem suitable for sutures which require to be retained a considerable time.

The following is an abstract of the paper by Mr. HENRY MORRIS on Two Cases of Unreduced, and Two Cases of Reduced, Dislocation of the Hip. In Case 1 an impacted fracture of the neck of the thigh-bone occurred in an old man, who had for years had an unreduced dorsal dislocation of the same thigh. Under examination the impaction was broken down and the limb brought straight, and therefore into a much better position than it was prior to the second accident. Union of the fracture followed with the two limbs paralysed. It is suggested: (1) that in certain cases of unreduced dislocation subcutaneous division of the neck of the bone should be performed, with a view to correct the more extreme inconveniences of the dislocation; (2) and that in all irreducible dislocations with fracture of the neck or shaft of the thigh-bone the fracture should be so set as to get parallelism of the limbs by causing the fragments to unite at an angle.—Case 2 is an unreduced dorsal dislocation with fracture of the rim of the acetabulum in a young and active man. The dislocation is of fourteen months' standing, and was caused by a fall from a height during a walk in a state of somnambulism. At first the symptoms of dorsal dislocation were absent, and it was thought the trochanter major was fractured and slightly displaced upwards and outwards, but whilst lying in bed the limb gradually shortened, and at the end of ten weeks had assumed the characteristic signs of dorsal dislocation. The feature of interest is the marvellous mobility of the unreduced limb, which is capable of every form of movement common to a ball-and-socket joint, and to an almost perfect degree. It is suggested that this freedom of movement, whilst in large part due to the activity and perseverance of the patient, is also largely the result of the dislocation being direct, the result of previous fracture of the acetabulum. The head of the femur rests upon the bone of the pelvis, and is strapped down and steadied by the rotator muscles, whilst the neck is not wound round the capsular ligament, as in the case of indirect dorsal dislocation, in which the head of the bone mounts over the rotator muscles, so as to have them between it and the dorsum ilii. The case shows how a dislocation may insidiously follow fracture of the rim of the acetabulum by the mere continued traction of muscular action.—Case 3 is a thyroid dislocation reduced by manipulation after having been converted into a dorsal dislocation. The peculiarity (as it must be called if the text-books are correct) of the case is the shortening of the limb one inch and a quarter; but probably in all obturator luxations the lengthening is only apparent and due to the extreme tilting of the pelvis.—Case 4: This is a dorsal luxation of the ordinary type, and reduced by manipulation in the ordinary way. The head of the bone during reduction could be plainly felt traversing its way to the lower edge of the acetabulum—i.e., retracing the course along which it was displaced. This case and Case 3, in which the thyroid was converted very easily into a dorsal dislocation, and, indeed, all cases of pubic and thyroid luxa-

tions which are changed into posterior luxations, afford additional arguments in support of the views previously published of the author—viz, that in all the ordinary dislocations backwards without fracture, whether they are spoken of as "dorsal" and "sciatic," or, as Bigelow styles them, "dorsal above" and "dorsal below the obturator tendon," the femur leaves the acetabulum through a rupture of the thin part of the capsule, and below the internal obturator tendon; that herein we have the *rationale* of the success of the method of reduction by manipulation; and that posterior, as well as anterior, dislocations occur whilst the limb is abducted. The chief museums of England, Ireland, and France have been searched for specimens of hip dislocation, with the result that there is not a single example of simple, uncomplicated, direct posterior dislocation above the obturator internus, but many of secondary dorsal and sciatic luxations—that is, luxations in which the head of the bone, having left the socket below the obturator internus muscle, had ridden upwards over it into its new position. Special reference was made to Sir W. Mac Cormac's case in St. Thomas's Hospital Museum, and a diagram of it was shown.—Mr. EVE said that his remarks in his own paper were chiefly devoted to confute the view that dorsal dislocations never occur without fracture of the acetabulum or femur; he had quoted in support Sir W. Mac Cormac's case. Mr. Morris now admitted that this was a direct dislocation backwards. Sir W. Mac Cormac described it as a direct dislocation backwards, and said he found the head of the bone lying above the obturator internus muscle. Even if there were laceration of the lower part of the capsule, produced by the injury, the case still showed that dorsal dislocation may take place without fracture of the femer or acetabulum. Mr. Wormald, in his case, says the opening in the capsule was opposite to the tuber ischii, and the dislocation was produced by a blow on the knee with the thigh flexed; and this case Mr. Eve believed to be a dislocation backwards. On dissecting the specimen Mr. Eve found the lower part of the capsule intact. There was another specimen in St. George's Hospital to the same effect. In Mr. Morris's plate of indirect dorsal dislocation the capsule is ruptured; and in his experiments Mr. Morris found the rent of the capsule always in the lower part. Parmentier records a case of direct dorsal dislocation without fracture of the acetabulum, but of pelvis. He still thought Mr. Morris's views at variance with those of the chief authorities, who hold that dorsal dislocations take place when the limb is adducted and flexed. Mr. Eve did not contend that all posterior dislocations are direct, although they are common as compared to indirect, and he admitted that direct dislocation was frequently associated with fracture of the rim of the acetabulum.—Mr. MORRIS having expressed his indebtedness to Mr. W. Adams and Mr. Frank Steele for drawings illustrating his paper, replied that there was not the least difficulty in understanding how the laceration in the lower part of the capsule in Sir W. Mac Cormac's case was overlooked, because no attempt was made, either before or after death, to reduce the dislocation; and the opening cannot be seen until the femur is raised and search is made expressly for it. His contention had been that direct dorsal dislocation and dislocation into the sciatic notch are not direct unless complicated by fractures, and that it was illogical to quote cases such as Mr. Wormald's and Mr. Adams's, which are dislocations below the obturator internus tendon, as direct dorsal or ischiatic dislocations.

The Society then adjourned.

CLINICAL SOCIETY OF LONDON.

Suppression of Urine after Ovariotomy.—Erythema Iris.—Aneurism of the Ascending Aorta.

THE ordinary meeting of this Society was held on Friday, February 10th, Joseph Lister, Esq., F.R.S., in the chair. Dr. Finlay showed a case of aneurism of the ascending aorta. Dr. Colcott Fox showed a case of anæsthetic and tubercular leprosy in a boy from the West Indies. Mr. Balmanno Squire exhibited three cases of lupus in one family, and two cases of lupus treated by linear scarifications, one of which, after an interval of three years, remains quite sound.

Mr. KNOWSLEY THORNTON brought forward a case in which Suppression of Urine was threatened several times after Ovariotomy; on each occasion packing the arms in cold wet towels relieved the symptoms, and the patient made a good recovery, and has remained in perfect health since. The following is a brief outline of the case:—J. W——, aged thirty-nine, married, and mother of two living children, the youngest seven years and a half old, was admitted into the Samaritan Hospital in Oct. 1880.—History: Never strong; during the last seven years has had three stillborn children and two miscarriages. Since last miscarriage has had irregular and too frequent menstruation. Abdominal tumour first noticed early in last pregnancy, Sept. 1879. A few weeks before admission, Dr. Pierce of Denbigh tapped the tumour, and removed twenty-four pints of greenish fluid.—Condition on admission: Looks older than her age, and has a waxy skin; kidneys act badly, and skin is dry and hard; no albuminuria. Ovariotomy performed Nov. 4th, 1880, and tumour of right ovary removed, weighing, with contents, 28 lb. Operation of average difficulty. A good deal of sponging necessary, and occupied an hour. Temperature and pulse rose rather rapidly, and on the day after the operation the urine was scanty and dark, and the kidneys were very irritable. Digitalis and citrate of potash were given, and next day the urine was free, and loaded with lithates. On the fourth day the kidney irritability returned, and the temperature and pulse rose again; sympathetic vomiting came on; and on the sixth day, the condition appearing critical, the arms were bound and packed in cold wet towels, which were kept wet with iced water. In twelve hours all bad symptoms had disappeared. The towels were allowed to dry, and in five hours the patient was as ill as ever. The towels were wetted again, and were kept applied for forty-eight hours, during which time the patient appeared quite well; and the wound was dressed for the first time, and found soundly healed, and all the sutures were removed. The towels were removed; but during the day the kidney symptoms and sickness gradually returned, and they were reapplied. Temperature and pulse remained unaffected, but the kidney symptoms at once yielded. On the eleventh day they were again removed. On the twelfth, the temperature being normal, the patient was allowed to get up. A few days later she went home; and Dr. Pierce writes that she is now in better health than she has enjoyed for some years.—*Remarks:* Mr. Doran has shown by his post-mortem examinations that advanced granular disease of the kidneys is common with large abdominal tumours; and it is known that this condition frequently exists without any clinical evidence of its presence. In the present case no albumen was detected, and though the kidneys acted badly before the operation, they were equal to the excretion of a fair quantity of urine loaded with lithates on the second day after the operation. The symptoms detailed in the paper were clearly due to the kidney condition, and the application of cold wet pack to the arms on three separate occasions acted like a charm. To what is this rapid action to be ascribed? The author discussed the methods of applying dry and wet cold not only to reduce temperature, but to relieve serious internal congestions; in the latter class of cases he believed the action to be a reflex one through the nervous system, and not a mere cooling of the blood generally. He referred to the action of internal chill in producing internal inflammations, and to the well-known action of counter-irritants. While believing that ordinary cases may be explained by one or other of the theories mentioned, he is still at a loss to explain the rapid action on the kidneys in this case from such a very restricted pack. The repetition of the treatment and its unfailing effect on three separate occasions, and especially on the last, when pulse and temperature remained unaffected, make it a case of clearly demonstrated therapeutic action, not a mere coincidence.—Mr. LISTER agreed with Mr. Thornton that the relief of the symptoms was due to the treatment employed, and also that it must be explained on the theory of a reflex vaso-motor effect. Years ago Mr. Lister had shown that raising the arms acted not simply mechanically by emptying the veins, but also exerted nervous reflex effect upon the arteries of the limbs; and this fact explains a case he had met with in which a man who was obliged to stand for long periods suffered from pain in the testicle, which was relieved by resting the feet up, no doubt due to a reflex emptying of the vessels of the testicle, similar to that in the legs. The well-known relief of pelvic congestion which often follows raising the legs, and the checking epistaxis by raising the arms, were explicable by the same theory.—Dr. THEODORE WILLIAMS asked what the temperature was in Mr. Thorn-

ton's case. In his experience when he had tried the ice-cap to the scalp in pneumonia or other local inflammation it had always failed, but it succeeded where the rise of temperature was due to a general cause.—Dr. WILTSHIRE asked if the operation was performed antiseptically.—Mr. THORNTON replied that it was antiseptic; that in any future case he would try the effect of raising the arms, and, disagreeing with Dr. Williams, found that the ice-cap was most useful in local inflammations, but that when there was rise of temperature from a general cause it failed completely.

Mr. BALMANNO SQUIRE read notes of a case of Erythema Iris exhibited at the last meeting. A woman, aged twenty-eight, presenting a copiously sprinkled eruption, limited to the palms of her hands and fingers, and to the backs of the ends of her fingers. The eruption had lasted a month, and was the third within two years, the previous attacks lasting three weeks. Each spot consisted of a circumferential, definitely raised, faintly pink ring, enclosing a disc-shaped, flat, unraised, brown-crimson, abruptly limited stain, disappearing momentarily on pressure, the centre of the spot being faded and of a pale buff colour; the average diameter of the spots, including the ring, was eight millimetres. The eruption was attended with a sensation of itching, and occasionally of burning. There was also considerable tenderness of the affected skin, so as to preclude any use of the hands. There was neither desquamation nor vesication, but the patient states that the previous attacks had terminated in free desquamation.

Dr. FINLAY showed a case of Aneurism of the Ascending Aorta in a woman aged thirty-two. She complained only of shortness of breath on exertion, and a slight cough at times; she had no difficulty in swallowing, and the pupils were equal. An oval-shaped pulsating swelling, three inches by two inches and a half, and projecting about half an inch from the surface of the chest, appeared to the right of the sternum, and extended in an almost vertical direction from the lower border of the second rib to the lower border of the fourth costal cartilage. There was no discoloration of the skin or enlargement of the cutaneous veins. Over the swelling there were a thrill and a loud double murmur, the diastolic part being loudest and longest. A double murmur was also heard at the heart's apex, which appeared in the fifth interspace in the nipple line. The murmurs were heard generally all over the chest, both back and front. They were also heard in both cavities, and there was visible pulsation of the vessels of the neck. Dull percussion was found over the tumour, shaded off for some distance beyond. Inspiration was wavy at the left apex in front, and expiration prolonged over the right upper scapular region. The appearance and action of the vocal cords were normal. There was no specific history; the patient was married but childless, and had had no miscarriages. She had a severe attack of rheumatic fever at the age of twenty, and thinks she strained herself four years and a half ago while engaged in house-cleaning. A year later a continuous, dull, aching pain in the right side of the chest began to trouble her; and on examining the part she discovered pulsation and swelling. She was admitted to the Middlesex Hospital, and remained there from January 22nd to July 7th, 1879, being treated with gradually increased doses of iodide of potassium, confined strictly to the recumbent position, and dieted on the plan advocated by Mr. Tufnell. After nearly six months of this treatment she was discharged much relieved, being free from pain, and with diminished pulsation in the aneurism; there was, however, no evidence of consolidation. Since her discharge she had continued to attend the out-patient department. Comparing her condition and physical examination when in the hospital with what it is now, the following differences appeared: At the former period the diastolic sound over the tumour was accompanied by a "thud" indicating the competent closure of the aortic valves; the situation of the apex beat was normal, and the heart's sounds there were unaccompanied by murmurs. Now the thud has disappeared; the apex beat is somewhat outside its normal position; and there is a murmur at the apex both with the systole and diastole. The pulsation in the tumour, too, feels more superficial now than it did then. From the comparison the sequence of events seemed to be, weakening of part of the wall of the aorta in connexion with the attack of rheumatic fever, and its giving way under the strain referred to; then the gradual dilatation of the aneurism leading to incompetence of the aortic valve, and this in turn to dilatation and hypertrophy of the left ventricle with mitral incompetence. The question for consideration now, seeing that medical treatment had so far failed, was whether it would be proper to resort to operative procedure; and if so, what that procedure should be. Galvano-puncture might commend itself to some; the distal ligature, as exemplified in cases recorded by Dr. Cockle and Mr. Heath, Mr. Holmes, and Mr. Barwell, to others. There seemed to be points in the case both in favour of and against operative interference. In the former category might be mentioned the youth, good general health, circumscribed appearance of the aneurism, and absence of pressure signs; on the other hand, there were the nearness of the aneurism to the aortic orifice, and the aortic regurgitation, which would expose to the danger of portions of clot being washed back into the left ventricle, together with a greater risk, than in cases where the valve was competent, of clots being detached and carried forwards in the other direction. At the same time the regurgitation might be slight, judging from the small amount of dilatation and hypertrophy. Altogether the *pros* and *cons* seemed so equal that it was difficult to strike a balance in favour of either side; all the more so when it was considered that the patient was not unlikely to live for a considerable time in fair comfort without surgical treatment.—Dr. DOUGLAS POWELL said, that before operative treatment was undertaken it was very important to make an accurate diagnosis; 1st, as regards the interpretation of the diastolic murmur—was it due to aortic reflux, or was it aneurismal? 2ndly, was it a sacculated aneurism? The relief following Tufnell's treatment was in favour of sacculation, and also its being near the surface, but clearly there was no clot now. He thought the second murmur was aneurismal—first, because there was no diastolic murmur at an early period of the case; secondly, because there was some evidence that the valves close; thirdly, the murmur was more distinct above the aneurism than below towards the epigastrium; and, fourthly, there was a second thrill. He thought that distal ligature would be the right course if his views on these points were correct, but that the case should be examined by others. Dr. Powell had published several cases of aneurism preceded by aortic regurgitation following acute rheumatism.—Dr. DE HAVILLAND HALL had seen Dr. Hughes Bennett's case treated by galvano-puncture; it was similar to the case exhibited, but though the skin was thin the man refused operation for some time, and after it was done suppuration occurred at the site of the needle puncture, and the man died from hæmorrhage. The unfortunate result was largely due, he thought, to delaying the operation until too late.—Dr. LONGHURST thought that operative interference was out of the question, and that Tufnell's treatment was the most suitable for the case.—Dr. THEODORE WILLIAMS had noticed that even where there was great thinning of the skin the rupture generally took place posteriorly, and related a case of a man with thinning of the anterior wall of the aneurism, treated by a modified Tufnell plan in which the wall got thickened and pulsation ceased, but the man left the hospital too soon, went to his work, and soon after the aneurism ruptured posteriorly.—Dr. GREEN asked whether the sphygmographic tracing would not afford satisfactory evidence of the condition of the aortic valves? In two of his cases, while galvano-puncture did no harm it did no good in one, and produced only a slight diminution of pulsation in the other.—Mr. HOWARD MARSH alluded to a specimen in the museum of St. Bartholomew's, taken from a man whose aneurism produced great bulging, but by rest the pulsation subsided and he left the hospital, and shortly afterwards in a drunken brawl the aneurism burst. Last year he tied the subclavian and carotid for what looked like an innominate, but some thought an aortic, aneurism. After the operation pulsation ceased over the thin part, but the aneurism bulged posteriorly, and ultimately the man died from the sac bursting through the site of the incisions for tying the arteries. He agreed with Dr. Williams that aneurisms most often burst posteriorly. Although the distal ligature was sometimes useful, the prolongation of life had not been great except in Mr. Heath's case, but that might be due to the operation having been done only in desperate cases, but he thought Dr. Finlay's case was a suitable one for this operation. Galvano-puncture was a failure in his experience.—Dr. FOWLER thought the diastolic murmur was only in part aneurismal. He deprecated any operative interference.—Mr. ROBERT PARKER thought that one cause of failure of galvano-puncture was that batteries unsuitable for electrolysis were often used. Every battery ought to be fitted

with a galvanoscope, otherwise, as he had found in treating nævi by electrolysis, there might be no action in the battery without the operator being aware of it.—Mr. WALSHAM thought the aneurism was too near the heart for distal ligature to succeed, and therefore recommended Tufnell's treatment.—Dr. SILVER alluded to Mr. Heath's case, which was exactly like an innominate aneurism, and had the patient not been a confirmed drunkard her life would probably have been prolonged for more than four years.—Dr. DOUGLAS POWELL, having looked at the sphygmographic tracing, considered it more indicative of aneurism than of aortic reflux, but thought the case would be a good test of the diagnostic value of the sphygmograph.—The PRESIDENT having appointed Dr. Powell and Dr. Green to investigate the case with Dr. Finlay, especially with regard to the question of aortic reflux, Dr. FINLAY replied. He referred to Dr. Ord's case of galvano-puncture forty-nine days after operation. Aortic regurgitation was present in that case, and although the patient died, his death was not apparently due to it. Nevertheless, he thought galvano-puncture was more dangerous than distal ligature in such cases, as the clot was more liable to be washed away.

The Society then adjourned.

HARVEIAN SOCIETY OF LONDON.

AT a meeting of this Society on Feb. 2nd, Mr. William Hickman (President) in the chair, Dr. DAY read a paper "On Headaches in Children." He alluded to the two great factors of headache from a pathological point of view—viz., cerebral anæmia and cerebral hyperæmia. Attention was directed to the fact that the amount of blood in the brain is influenced by the fulness of the ventricles, the subarachnoid spaces, and the lymphatic spaces, or sheaths, surrounding the cerebral bloodvessels. Dr. Day said that habitual headaches in children indicate an irritable and exhausted brain, and if intellectual exertion be carried too far in such cases mischief is soon likely to ensue. It seemed extraordinary that educated men who had the care of young persons should not see this danger in the anæmia produced by over-study, the irritability and excitability of manner, and the impossibility of concentration, so necessary to the accomplishment of any undertaking. If intellectual exertion be carried beyond a certain point the brain becomes anæmic, fatigued, and the nutrition in the ganglion cells of the cortex becomes impaired, diseased, or in some way altered from health. The author referred to neuralgia, or one-sided headache, which, he said, was more common in children than was generally supposed; it was not infrequent in those of the neurosal temperament, whose nervous system was easily exhausted, and in those reduced by long and exhausting illness, bad food, and other causes. He had known headache in connexion with chorea and dental caries. Next he spoke of congestion, toxæmic and organic headaches.—Dr. CHEADLE considered foul air and gas were the chief causes of study headaches. He had noticed headaches from this cause, especially in choristers; he referred to headaches in rickety children; this occurred just after the skull closed, was continuous, but gradually subsided.—Dr. STEPHEN MACKENZIE wished particularly to insist on the importance of careful examination of the eyes in cases of headache in children. Muscular asthenopia was a cause of headache which sometimes was mistaken for serious organic disease. He mentioned the case of a schoolboy brought to him under this supposition, but myopia was found and corrected, and the headache disappeared. The same thing occasionally occurred with hypermetropia. Next he pointed out that ear disease was sometimes the cause of headache, which was of importance as significant of commencing meningeal or cerebral inflammation. In all cases, therefore, of headache in children it was very important to examine the ear and the eye, using the ophthalmoscope, which was of great value in detecting organic disease. He remarked that pain in the head, a valuable sign of tumour of the brain, was no certain indication of the localisation of the tumour, unless there was corresponding pain on percussion.—Mr. CRIPPS LAWRENCE asked if the urine was altered in these cases, especially as to its specific gravity.—Mr. MALCOLM MORRIS considered that headache in some cases might be a distinct disease and not merely a symptom, as when an attack occurred and passed off suddenly in a person whose functions were normal at the time.—The PRESIDENT said that headache, though not a common symptom in children, was one of import, and frequently indicated advanced disease.—Dr. DAY, in reply, remarked that the urine was usually healthy; the specific gravity was high.

MIDLAND MEDICAL SOCIETY.

AT a meeting of this Society, held at the Medical Institute, Birmingham, on Wednesday, the 1st inst., in the absence of the President, Dr. Bassett was voted to the chair.

Mr. BENNETT MAY showed two specimens of Knee-joint Disease which had originated in acute necrosis of the head of the tibia.

Mr. A. O. HOLBECKE showed the Left Hemisphere of the Brain of a child aged eight years, exhibiting a large abscess cavity from which about half a pint of most offensive pus had escaped. On making the post-mortem examination, a small round perforation in the petrous portion of the temporal bone was found, which communicated with the ear on the one hand and the abscess cavity on the other. The dura mater was healthy. Thirteen weeks before death the child had received a blow on the ear, and complained of much pain at the time. Subsequently her health became impaired, and a discharge of pus from the left ear appeared, the pain in the head becoming relieved. Several times this discharge disappeared, the pain in the head being always simultaneously increased. There was no paralysis. Convulsions had occasionally occurred. She was rational, and answered questions intelligently. Twelve hours before death the discharge from the ear ceased, and she at once became comatose and died.

Mr. A. O. HOLBECKE also showed the following specimens, all taken from the same patient, aged sixty:—(1) An Ununited Fracture of the Humerus. (2) Two Fractures in the Femur, united firmly but irregularly, and causing much shortening. (3) Two large Deposits in the Liver (together with microscopic specimens of the same, prepared by Dr. Barling), which presented the characters of carcinoma. (4) A Calculus removed from the Gall-bladder. (5) The Right Kidney studded throughout with calculi; the Left Kidney, presenting well-marked granular degeneration. The fractures had occurred last June. Her left mamma had been removed nineteen years previously for scirrhus. Her father died of cancer.

Mr. JORDAN LLOYD showed a specimen of Central Necrosis of the first Phalanx of the Index-finger without suppuration, attended by the expansion of the whole bone into a cyst with very thin walls, the cartilages being healthy. In another case Mr. Jordan Lloyd would try to save the member by removing elliptical pieces from the bony shell before proceeding to amputation.

Mr. HUGH THOMAS showed the following specimens:—(1) A Placenta studded with deposits of Calcareous Degeneration, and having an abnormally short cord (only eight inches long), taken from a primipara, aged twenty-two, in whom ante-partum hæmorrhage, followed in eight days by premature labour, occurred about the seventh month of pregnancy; the child was stillborn, the cuticle peeling off. (2) A specimen of Scirrhus of the Rectum, taken from a man aged fifty-seven, in whom after prolonged constipation death occurred from peritonitis, set up by a perforation of the gut having occurred just above the stricture, which was about an inch and a half from the anus. (3) A Uterine Fibroid, expelled by a woman aged forty, the mother of seven children, immediately after parturition.

Mr. LAWSON TAIT read a paper on Death after Ovariotomy due to Previous Tapping. The author drew attention to the fact that amongst the last hundred ovariotomies (for cystoma) which he had performed there had been only three deaths. In all the deaths had been due to the formation of a firm white clot, which started from the point of ligature of the pedicle and slowly traversed the venous system till it reached the heart, death ensuing in from thirty to forty hours after operation. The symptoms which preceded death were swelling of the legs, rapid rise of pulse, and its disappearance from the extremities some time before death; breathlessness ending in suffocation, and slight delirium. He had seen several such deaths, but not one in a patient who had not been previously tapped. His explanation

was that the repeated tappings deprived the blood of some element, or elements, included in the infinite variety of albuminous substances found in ovarian cysts, the deficiency of which predisposed to coagulation of the blood. The author thought that no case of ovarian tumour should be tapped till previous abdominal section had shown that it could not be removed. He believed if this rule was followed the mortality might be reduced to less than 1 per cent. if cases were operated on early. As long as the clamp gave a mortality of 25 per cent. it was right to stave off by all possible means so fatal an operation as ovariotomy.

Mr. LAWSON TAIT also read a paper on Two Cases of Hydatids of the Peritoneum successfully treated by abdominal section. In the first the operation was incomplete, because the hydatids had so matted the intestines together that the larger number could not be removed. All the cysts were broken down, and a drainage-tube inserted into the pelvis from above. The patient's symptoms previous to the operation were very severe, but they rapidly disappeared. The patient completely recovered, and the hydatid masses had entirely gone when she left the hospital twenty-four days after operation. The second case was of a more simple kind, for the parasites were contained in a cyst in the lower abdomen, which was completely emptied, and drained through the wound. The patient made an easy, rapid, and complete recovery.—A discussion followed in which Dr. Bassett, Dr. Carter, Mr. Jordan Lloyd, and Mr. Bennett May took part, and Mr. Tait replied.

Dr. SIMON read a paper on the Treatment of Eczema. In the discussion which followed, Dr. Bassett, Mr. Greene, Mr. Mann, Mr. Lawson Tait, Mr. Bennett May, Mr. Taylor, and Dr. Johnston took part, and Dr. Simon having replied, the meeting terminated.

Rebiews and Notices of Books.

Scrofula and its Gland Diseases. By FREDERICK TREVES, F.R.C.S., Assistant-Surgeon and Senior Demonstrator of Anatomy at the London Hospital, late Wilson Professor of Pathology at the Royal College of Surgeons. London: Smith, Elder, and Co. 1882.

MEDICINE has never wanted a "limbo" to which disorders that have been imperfectly studied could be conveniently consigned. During the first half of the eighteenth century scurvy occupied this border region. Physicians of that era, by collecting from each other and by individual additions, made up a very extraordinary number of scorbutic symptoms, so that at last they ascribed to this disease almost every distemper and frailty incident to the human body, and seemingly left no room for further invention. When, however, it became clearly understood that scurvy and scorbutic symptoms promptly yielded to the administration of small quantities of lemon-juice, the disease speedily lost its hold on the imagination of pathologists. Scrofula then assumed the dominant position it held till quite the middle of the present century. Not merely were all manifestations of hereditary syphilis classed as scrofulous, but rickets, favus, diabetes, gravel, gout, and even cancer, were referred to it. The advance of chemical science, and the discovery of uric acid in the blood of patients suffering from gout, opened a new field for speculation and hypothesis, so that at the present time gout may be considered as holding the debatable ground for vague generalisation and for all that is unknown and uncertain in pathology. To the lack of scientific limitation in the pathology of Scrofula, and to a cumbrous heritage of opposed opinions and diverse theories, Mr. Treves attributes the neglect that has of late years befallen the study of this disease; indeed so great has been that neglect that the author may be considered as entering a new country, and describing for the first time its general aspect and territorial limits.

The general Pathology of Scrofula is first discussed. The various views of the relationship of scrofula to tubercle are clearly enunciated, and the whole question elucidated with admirable conciseness. We doubt whether a more complete summary of the views of the different pathologists who have recently worked on the subject of tubercle can be found elsewhere. The conclusions arrived at by the author with regard to this part of his subject may be thus briefly summarised: 1. That the manifestations of scrofula are commonly associated with the appearance of tubercle. 2. That the form of tubercle met with in scrofula is elementary and immature. 3. That scrofula indicates merely a milder form or stage of tuberculosis, and that the processes are simply separated from one another by degree.

The Nature of Tubercle is then treated of, and Mr. Treves strongly advocates the view that tubercle is merely a product of a peculiar form of inflammation, and not a neoplasm, and he brings forward some weighty evidence in favour of this theory. Presuming tubercle to be a neoplasm no other new growth is so intimately associated with inflammatory change; whilst its spontaneous curability is certainly more in favour of its inflammatory origin. In support of this view he quotes the experiments of Ziegler, in which tubercle was found in the inflammatory changes induced in animals, when two thin discs of glass, so cemented together that fine interstices were left between them, were inserted under the skin; on removal and examination of the discs perfect tubercle was found in the inflammatory exudations in these interstices.

In the original and ingenious chapter on the Antagonism between Scrofulous Diseases many obsolete and incorrect notions are swept away. Mr. Treves shows by statistics that the commonly received view that the majority of scrofulous subjects die of consumption is incorrect; and that, on the contrary, phthisis is by no means a common complication of scrofula. He proves, from the records of the Margate Infirmary, that the particular scrofulous malady any given patient possesses appears to protect him from any other outcome of the disease; and, finally, originates the view that there is a decided antagonism between scrofulous affections.

In treating of the various symptoms presented by the scrofulous individual, the author draws attention to the statement of Dr. Paul concerning the changes in the ears after they have been pierced by ear-rings. The puncture in these cases very slowly ulcerates, and Dr. Paul concludes every woman in whose ears the scar left by piercing is in the form of a slit-like orifice, or a linear cicatrix, is the subject of scrofula. Mr. Treves, from a consideration of an extensive series of cases, is unable to corroborate the statement. Moreover, as he pertinently asks, if the condition be due to general tissue defects, how comes it that in one-third of the cases only *one* ear is affected? The pathology of the so-called "cold abscess" is included in this chapter, and is set forth in a manner that cannot fail to interest the histologist.

Part II. relates especially to the Scrofulous Gland. The anatomy and etiology are clearly given. The questions of the nature of the peripheral lesion that induces gland disease, and why of all other external glands those in the cervical region are so often the seat of strumous disease, receive an explanatory light from the observations of the author. He believes that the peripheral lesions most active in exciting gland disease in scrofula are those that are located in the adenoid tissue of a mucous membrane. This varies greatly in amount in different parts, but is particularly abundant in the mouth and pharynx, in the bronchial mucous membrane, and in the intestines. Now, the glands most commonly affected with scrofulosis are the cervical, bronchial, and mesenteric.

The chapter dealing with the Pathological Histology of the Scrofulous Gland is perhaps the best in the book. We congratulate Mr. Treves on the results of the vast amount of labour he has so evidently expended on the subject. The

author draws attention to the traditional error that the changes in the glands are first observed at their extreme periphery, the exact converse holding good. He also refers to the changes that take place in the lymphatic vessels proper to the gland tissue. The nature of the giant cell is urged to be that of a coagulum formed in the irregular meshes of the fibrous tissue of the gland. With regard to this theory of their origin, we do not see why the *large* cell elements should occupy an intermediary position. The large cell elements, according to this theory, would arise from the endothelia lining the reticulum. They ought, therefore, rather to lie on the periphery of the giant cell. Still, the fact that in a decaying giant cell a network can be seen stretching across the mass, exactly similar to that in the vicinity, and that this reticulum is continuous with the so-called processes of the giant cell, and through them with the neighbouring adenoid tissue, is strongly corroborative of the truth of this suggestion of their mode of origin.

Mr. Treves next points out the various symptoms of the affection, and finally discusses the treatment, especially as regards operative measures. The indications for excision, scooping, and cautery puncture, are clearly pointed out, much stress being laid on the excellent results obtained from the latter method.

Mr. Treves has produced a work of which he may feel justly proud. The clinical portion of it fully sustains the reputation English surgeons have acquired in this department of scientific observation, whilst the chapters devoted to the consideration of the pathology of the disease lead us to hope Mr. Treves will soon have more followers in this field of original research. In conclusion, we may add that we have only one fault to find with the author—namely, that he has limited himself to the gland diseases arising from scrofula, and has not dealt with its other surgical manifestations, especially those affecting the bones and joints. This is an omission which we hope the author may soon have the opportunity of rectifying.

The South of France, &c. Edinburgh: A. & C. Black.

THIS is a handbook which will prove of good service to those who by necessity or inclination make their home for the winter in the South of Europe. It comprises all those places which a sojourner in the South is likely to visit—the South-east of France, with Avignon, Nismes, Arles, and Marseilles, the French and Italian Riviera, and parts of Italy as far south as Florence. There is also a guide to the Island of Corsica, an island which is too little visited. To the pedestrian who does not mind a very moderate amount of roughness, Corsica affords a most interesting touring ground, and its picturesqueness, even in the depth of winter, is quite exceptional. This work, for convenience and accuracy, seems to be quite on a par with the rest of Messrs. Black's well-known guides. The only fault we have to find with it is that it is not dated, which forces upon us the reflection that possibly some of the information is obsolete.

The Irish Medical Directory for 1882. London: Baillière, Tindall, & Cox.

IN glancing through the pages of this Directory we were struck by the large proportion of the names of our Irish *confrères* to which an asterisk is attached, signifying, as we are told, that their owners had omitted to reply to the repeated requests for information urged by the publishers. Thus, opening at random, on page 20, of sixteen names eleven are distinguished by the above-mentioned prefix. We note the fact without venturing on a surmise as to its cause. A mass of useful information is compassed by the volume, which will maintain its place as a reference book in medical matters in the Sister Isle.

THE DANGERS OF CHLOROFORM AND THE SAFETY OF ETHER AS AN ANÆSTHETIC.

To the Editor of THE LANCET.

SIR,—I regret to find that, notwithstanding all that has been said and written concerning the safe and dangerous anæsthetics, we still, week after week, meet with the following distressing heading:—"Another death from chloroform." Last week I see three cases of death reported from this cause; one as occurring at Malvern, another at Dundee, and a third at a London Hospital. To these cases I wish in no way further to refer. I feel sure that all due precaution was attended to, and that the finding of the jury was correct, viz., "Died from natural causes, accelerated by chloroform judiciously and properly administered." But what I particularly wish to draw attention to is, why should the use of chloroform be continued as an anæsthetic, when so many deaths have been either occasioned or accelerated by its use?

The cool and apparently indifferent manner in which these sad cases are recorded from time to time impressed me with an idea that familiarity with "chloroform deaths" seems to have dulled the feelings of operating surgeons, and that fatal cases of anæsthesia from chloroform have come to be regarded as an unavoidable tribute to convenience rather than as an evidence of carelessness and misguided judgment.

Hospital surgeons as a body must run their chance of having deaths by misadventure, no matter from what cause, but they should certainly be liable to blame in the eyes of the public, if they merely used chloroform because it was rapid in action and pleasant to take, to the exclusion of other anæsthetics *eight times safer*, but not perhaps so quick in action or so easy of administration. The question is now becoming a very important one, and it is high time something should be done so as to arrive at some guiding rule regarding the choice or selection of the means that ought to be employed in rendering patients insensible to pain during the performance of surgical operations.

It is very probable that a day will come when operators will not be allowed to explain a death from chloroform as an "unfortunate thing" and a piece of bad luck, or that it was a sort of penalty the surgeon pays for using a rapid but dangerous anæsthetic. I do think, from all the warnings we have received, that the use of chloroform should be given up.

I am happy to say that in the various hospitals in Dublin very few surgeons use it. Throughout America it is seldom used, and why it should be given in England, and in some instances *single-handed*, is entirely beyond comprehension. A recent writer, when talking of its use, has said, "It is criminal and it is unscientific, and so much so as to justify the stern interference of the law, and the summary punishment of those guilty of culpable negligence."

Deaths have no doubt occurred when other anæsthetics than chloroform have been used. However, it is better for the surgeon and all concerned to think of safety to the patient rather than rapidity of action and convenience.

When we learn that only one death from ether occurred in 23,204 administrations, it is quite reason enough for those interested in the subject to urge and recommend its employment.

To place a patient in an insensible sleep never to wake again is a very serious matter. Few can realise it except those who have experienced the dreadful moments of doubt and mortification that take place. Restoratives are quickly employed in the hope of reviving the patient, but all to no purpose; the person lies dead before you who but a few minutes before was in full possession of life and strength. The sad news has to be told to anxious friends who are ready waiting to hear of the operation being over. I never found the administration of ether difficult with the "Pocket Inhaler," made for me by Coxeter, London. I have administered it to all ages, ranging from infancy to persons over eighty years of age, with the happiest results. Complete anæsthesia was rapidly produced with a small quantity of ether, and when consciousness returned no bad effects were as a rule complained of.

I am, Sir, yours, &c.,

LAMBERT H. ORMSBY, M.D., F.R.C.S.,
Surgeon to Meath Hospital, Dublin.

Merrion-square, Dublin, February 8th, 1882.

THE LANCET.

LONDON: SATURDAY, FEBRUARY 18, 1882.

A SERIES of experiments, which have been carried on at Wurzburg by Dr. ROSENBERGER, seem to involve important modifications in the views at present current regarding the development of septicæmia and of the organisms to which it is in apparent relation. It has already been found that a septicæmic virus, which has been exposed to a temperature sufficient to destroy all the bacteria it contains, will still cause the death of an animal into which it is injected. It is currently assumed that the animal is poisoned, not infected—i.e., that the virus causes death by its presence, not by its multiplication, and that a second animal cannot be killed by the injection of a small quantity of the blood or serum of the first, any more than in a parallel case of strychnine poisoning. To decide this question, septic blood and serum were heated, filtered, evaporated, and then injected. The animals died with all the symptoms and pathological appearances of septicæmia, just as if the uncooked virus had been used. Moreover, it was found that the blood-serum of the tissues and cavities contained the same micro-organisms and in the same quantity as animals into which the uncooked virus had been injected. The effect of heat was, however, to lessen greatly the virulence of the poison, so that a cubic centimetre was needed of a virus of which before the minutest quantity sufficed. Further experiments showed that septicæmia could be produced in other animals by the injection of even extremely small quantities of the blood- or tissue-serum of those that had been killed by the inoculation with the cooked virus, which appeared thus to have acquired by renewed development the intensity of which it had been deprived by heat.

An obvious objection to the experiments of ROSENBERGER is that the heat employed may have been insufficient in degree or in duration, and that some of the specific micro-organisms may have escaped its action. To meet this objection he exposed the virus to a temperature of 140° C. for two hours, and made the inoculation with a perfectly new syringe washed with carbolic acid and absolute alcohol, but obtained the same result. The fact that the virus was effectually sterilised, so far as organisms are concerned, was ascertained in each experiment by the addition of some of the virus to some extract of meat, which remained for weeks perfectly clear and free from organisms.

With KOCH and others, ROSENBERGER distinguishes two forms of septicæmia in the guinea-pig, similar in clinical symptoms and coarse pathological appearances, but differing in the form of bacteria to be found in the blood. The first form, known as "PASTEUR'S septicæmia" or as "malignant œdema," may be readily produced by the injection of some peritoneal fluid from an animal in which peritonitis has been produced by the introduction of a fragment of decomposing muscle into the abdominal cavity. In this form no organisms are found in the blood, or merely a few micrococci, while in the fluid of the œdema which forms around the place of inoculation there is to be found an immense quantity of large and small rod-shaped bacteria, and of micrococci. The second form, "DAVAINE'S septicæmia," may be produced by the injection of blood which has been undergoing decomposition for about ten days. The blood in this form contains small biscuit-shaped micro-organisms which are always absent in the other form, and, *à fortiori*, in normal animals. ROSENBERGER has succeeded in producing both these forms of septicæmia by the injection of the cooked virus, and with the result that the blood of the affected animal contained in each case the same organisms which were present in the virus before it was exposed to the action of heat. In the animal killed by the injection of the cooked poison of malignant œdema, the serum of the œdema near the seat of the inoculation showed the clear refracting rods and micrococci, although there were no organisms in the blood. In the other form rod-shaped and biscuit-shaped bacteria were found near the place of injection, but, in the blood, only the latter form. The organisms rapidly multiplied in culture liquids to which a drop of the serum or of blood had been added, and those liquids injected into other animals caused rapidly fatal septicæmia.

The inference from these experiments is that the application of a degree of heat which apparently sterilises effectually a septicæmic virus, so far as artificial cultivation of the organisms is concerned, does not prevent the virus from producing in the animal body its specific form of septicæmia and of septic bacteria. From these facts the startling conclusion is drawn that the bacteria are not primary but secondary elements in the morbid process, and that their development is associated with a chemical or at least unorganised poison. It is not asserted that the bacteria are without influence on the morbid process; on the contrary, ROSENBERGER believes that they alone are the means of multiplying the poison in the animal body, and in a culture fluid inoculated with the cooked virus and kept at a suitable temperature there is not only no growth of organisms, but also no increase of virus. If two similar culture fluids are inoculated, one with the cooked virus and the other with some blood of an animal which has been killed by injection of cooked virus, the former remains unchanged, and injected into an animal is without effect, while the other becomes opaque in the course of a few hours, and has developed powerful septic properties.

The development of the specific bacteria after the injection of the sterilised virus is explicable, ROSENBERGER believes, only on the assumption that they arise from non-specific bacteria previously present in the body, since, according to his facts, they arise independently of the introduction into the system of other organisms or other germs. This, it is needless to point out, is a conclusion scarcely less than revolutionary as regards certain theories of the origin of the specific organisms of disease. It is not, however, altogether unsupported by previous experiments. A year ago, BUCHNER published observations which seemed to show that the bacillus of anthrax might be developed from a non-specific fungus found in hay. His experiments were not, however, altogether conclusive; he obtained by the culture of the anthrax bacillus an organism which, in the fifteen hundredth generation, was identica in characters with one obtained by

the artificial cultivation of the hay fungus, but he failed to obtain, by injection of the latter, the specific disease which was produced by the former. Important and suggestive as are the experiments of ROSENBERGER, the conclusions which he draws from them are so much opposed to those of most previous experiments, that to many persons the most probable explanation will doubtless be the assumption that some germs must have resisted the action of heat, and have survived in a condition to develop in the favourable soil of a living organism, although not in a mere culture liquid. At the same time it must not be forgotten that septicæmia belongs to a class of diseases of low specificity, like typhoid fever, diphtheria, and erysipelas, the occasional origin of which by the transformation of a non-specific virus is highly probable. In connexion with his theory of the development of septic bacteria from non-specific virus some observations which have just been published by ROSSBACH also deserve mention. The latter has pointed out how constantly organisms in small numbers are present in the healthy blood, which appears to constitute a soil unsuited to their more considerable development. They may be demonstrated by the excision of parts of the body, and the immediate preservation of these in melted paraffin, or by the examination of the blood of the heart immediately after death. Larger quantities of organisms are almost universally assumed to have entered from without. But ROSSBACH, in experiments on the physiological action of papayotin, has found that an hour or two after the injection of a solution of this substance into a vein, the blood contains enormous quantities of micrococci, and even of round and biscuit-shaped bacteria, in lively movement, and responding to all the characteristic tests. Here, then, we have a case in which the blood of a perfectly healthy organism is so altered by the presence of a chemical ferment of vegetable origin and free from organisms, that the bacteria present in the normal blood increase with such marvellous rapidity that the state of the blood is comparable to that which results from a true infection. These facts thus suggest the same conclusion as do those of ROSENBERGER, and his theory derives from them considerable support.

THE great success which has attended the working of the Army Medical Department under the new organisation, as shown in the campaigns in Afghanistan and South Africa, cannot but have been satisfactory to those who brought it into operation as well as to those who supported it through all the opposition which it at first excited. The difficulties thrown in the way of its introduction, the unjustifiable abuse lavished on those to whom this duty was entrusted, and the confident predictions of a break down, were such as might have ensured its failure but for the judgment with which it was prepared, the firmness with which it was brought into operation, and the loyalty with which it was carried out by the administrative officers on whom the practical arrangements devolved. It was pretty well understood that the scheme for the abolition of the regimental and introduction of the station hospital system was viewed with anything but favour at the Horse Guards. The testimony therefore of the Field-Marshal Commanding-in-Chief as to the great success which has attended it is the more forcible as it was against his preconceived opinions, while the handsome manner in which his approval was expressed at Netley was worthy of the position of His Royal Highness. In speaking of the work done by the medical officers in these two wars the Duke of CAMBRIDGE said that he had been unable to put his finger on any defect in the organisation and working of the department, while the gallantry and devotion to duty of the medical officers called forth a warm encomium. Nor did he omit to notice, in terms of praise, the less conspicuous but no less real courage displayed by those who, in the epidemic of yellow fever at Barbadoes, had laid down their lives in the service of their country. We trust that the impression made upon His Royal Highness by the instances of zeal, efficiency, and courage which have been thus brought to his especial notice may not be evanescent, and that in future there may be no ground for the opinion which so generally prevailed in the department that at the Horse Guards there existed a feeling strongly antagonistic to medical officers. We would, at the same time, remind the officers of the department, and especially the younger ones, that the success which has attended the labours of their brother officers imposes upon them the important obligation of maintaining the high reputation which has thus been acknowledged, and of increasing the efficiency and the professional and scientific character of the branch of the service to which they belong.

THE difficulty in bringing home conviction to the right person in the case of infants who die from improper feeding is well known to everybody who has interested himself in the matter. The following is a typical case:—A servant gives birth to an illegitimate child. She is "confined" in a benevolent institution, where it is a *sine quâ non* that she shall wean her child within a month. The baby is put out to nurse and the mother has a situation found for her. In a few weeks the baby is brought to the doctor in a state of extreme marasmus. There may be excessive vomiting and diarrhœa, and then the child dies outright. But often it is a condition short of this: the child's bowels are a little relaxed and it vomits occasionally, but the main feature is that it wastes away. In most cases there has been improper feeding: corn flour, boiled bread, sour milk, foul feeding-bottles, and the like are no doubt responsible for a great deal, but it cannot be too strongly stated that deprivation of the mother's milk is the prime factor; and the responsibility of the benevolent but misguided people who insist upon the weaning of an illegitimate child with a view to getting the mother back into a respectable situation is very serious indeed. When such a child dies it is very hard in some cases to say that the nurse is blameworthy. Generally no food but mother's milk could possibly save the asthenic infant which is put out to nurse. The voice of the coroner on this question often gives forth an uncertain sound. We are glad to find, therefore, that in one of the large manufacturing towns of Lancashire there has been some plain speaking on this score. On the 16th ult. Mr. ROWBOTTOM, the coroner for Wigan, held inquests on two typical cases, to the report of which, as given in the *Wigan Observer* of the 18th January, we shall briefly refer. The first was on a child six months old, who had passed through an attack of whooping-cough, and who after the first month of life had been fed only on scalded bread, sugar, milk, and corn flour. The

infant was said to be pretty well, though of the truth of such a statement we may have our doubts in regard to a child fed upon so unsuitable a diet and approaching the unstable period of dentition; at all events the child died in a convulsion. It is very properly stated in evidence that the same mother had had before the one in question three other children, whom she had suckled, and who had all lived. The coroner seems to have insisted on the unsuitability of the farinaceous diet, but the jury felt themselves justified only in recording a verdict of death from convulsions. The second inquest was on a younger child, the daughter of a factory worker. The mother seems to have gone to work at the factory within about a fortnight after her confinement. She had given the child the breast twice or three times a day, and also at night, and during the intervals it had been "stuffed" with bread and milk. The child died suddenly, and it seems doubtful as to what was the immediate cause of death. It is quite likely, as the coroner insisted, that the breast milk of a woman who had gone to work so very early after confinement was defective, and no doubt the bread feeding was bad, but it would have been more satisfactory, especially as we have no statements as to the symptoms presented by this child before death, to have had an autopsy. It is extremely desirable, however, that the subject of infant mortality in the class of factory workers should receive thorough consideration. It is, perhaps, too much to expect at present that nursing mothers should stay away from the factories during the whole time of their lactation, though that, doubtless, would be the most economical in the long run in the preservation of the life and vigour of both mother and children. The stunting in growth of many of the factory workers unquestionably dates from the rickets of early life, and the working man ought to be taught that it would pay him better to let his wife stay at home and look after his comfort and that of his children instead of increasing the earnings at the cost of health. But is it too much to hope that some of the millowners, who are intelligent and benevolent men, should take this question to heart and minimise by every lawful means in their power the employment of young mothers in their factories? It has often been recommended that girls at school should be taught elementary truths about food and hygiene. We doubt very much whether any such instruction would be of material use in the class which so sadly needs it. In some of the large towns efforts are now being made to give instruction to the poor in simple cookery, especially in evening classes for young adults held in connexion with the School Board organisation and with the sanitary associations. We hope they will succeed, and that to these lessons there may be added some simple practical teaching on the feeding and nurture of infants.

WE have been favoured with the Minutes of a meeting of the Branch Council for England held on Thursday, Feb. 9th. The treasurer reported that, pursuant to instructions at the last meeting, they had invested £4015 in consols, making the total now invested by the trustees of the Branch Council £29,000 in consols.

The case of Mr. GEORGE HENRY LAMSON, as raised in the Council last year by Dr. FRAZER, the honorary secretary of the Bournemouth Medical Society, again came forward. It may be remembered that Dr. FRAZER wrote to the Registrar of the General Medical Council in April last in reference to Mr. LAMSON, registered on June 3rd, 1878, with the qualifications—Lic. R. Coll. Phys. Edin., Lic. R. Coll. Surg. Edin. His statement was to the effect that Mr. LAMSON made use of other titles—viz., M.D. of Paris and L.R.C.P. Lond.; and described himself as possessed of the Sanitary Science certificate of Cambridge. In regard to the last three titles, evidence was adduced in the form of letters from the Dean of the Faculty of Paris, the Registrar of the Royal College of Physicians of London, and Professor LIVEING of Cambridge, that Mr. LAMSON was not possessed of these degrees. Thereupon the Society resolved to remove his name from its list of members, and to send a copy of its resolution to the Medical Council. The Council, thinking that such conduct chiefly concerned the bodies whose diploma Mr. LAMSON held—viz., the Royal Colleges of Physicians and Surgeons of Edinburgh,—transmitted to them all the documents having reference to the case. The answer of these bodies was before the Branch Council on the 9th. The College of Surgeons of Edinburgh made answer that, as Mr. LAMSON had fulfilled all the requirements of the College both as regarded curriculum and examination, the Council of the College did not consider that the latter would be justified in taking any action against him upon the allegation that he had made use of titles of other bodies. "It appears to the Council," says the President of the College, "that any steps in regard to Mr. LAMSON should be taken by the General Medical Council alone." The College of Physicians of Edinburgh intimated to the Registrar of the Council that, in the absence of definite proof as to the facts of the case, the Council of the College could not see their way to take any steps in the matter.

Neither of these answers gives the impression that the corporations are very jealous for the honour of the profession. The College of Surgeons of Edinburgh would cast on the Medical Council the whole responsibility of investigating a series of alleged frauds affecting the honour of one of its licentiates. The Edinburgh College of Physicians, with equal ease, does not at present see its way to take any steps in the matter. The constant defence of the corporations is that they are the guardians of professional honour and morality. On the contrary, they wait for any other body to take action before they move, and meanwhile submit to much dishonour and involve the profession in discredit. There is too good reason for believing that Mr. LAMSON is not the only person who uses false titles, and even gets them inserted in the Medical Directory. The case should cause the publishers of that valuable book, and all the corporations concerned, to be on their guard against fraud. All respectable persons to whom the fraudulent use of titles is known would do a service to the public and the profession by informing the publishers of the Directory, and the universities and corporations whose titles are so misappropriated.

There is too great a division of responsibility amongst medical authorities in regard to behaviour of this sort. Another similar case was brought very carefully under the notice of the English Branch Council last year; but the bodies concerned, one of which was a university, were not

greatly moved, and the Council came to the conclusion that "the case did not seem one in which they could usefully take action." It would be a great advantage to the public if, in any impending legislation, greater security were taken against the false use of titles, degrees, &c., by assigning definitely the responsibility of taking action against those who offend.

Annotations.

"Ne quid nimis."

THE HEALTH OF THE QUEEN.

THE health of Her Majesty the Queen can never fail to be a matter of supreme interest to all classes of her subjects. The nation is at heart animated by a loyal concern for the personal happiness and welfare of its tried and trusted Sovereign. The people are stirred with feelings of mingled reverence for the throne and affectionate regard for its present occupant. It is no mere figure of speech to say that Queen Victoria lives in the hearts of those she rules over. It is, therefore, not in the least surprising that the notification of Her Majesty's projected visit to Mentone should have excited much remark, and given rise to some anxieties. We believe we are justified in stating that while there is need for the change there is no cause for concern as to the health of the Sovereign. It seems to have been forgotten that the Queen is no mere nominal head of this empire. Actual and heavy State business passes daily through her hands, and taxes her attention severely. Her Majesty has never been in the habit of attaching her sign manual to unread papers. She ascended the throne in times of difficulty, and with a strong sense of the duty and responsibility imposed upon her; and during the lengthened period which has elapsed since her accession the Queen has given a large share of her attention to public business. Successive Ministries have been formed, borne the heat of the day, and fallen, leaving their *personnel* to seek and find relief and recreation in retirement; but the Queen has never been free from the burden of State since first she wore the crown. It is a *real* burden Her Majesty bears, a burden of care and anxiety, and no human being could fail to feel the continuous strain the bearing of such a burden necessarily produces. These facts should not be forgotten. The need for change of scene and climate just now is great, but not in any sense ominous. If Her Majesty is able to enjoy a period of perfect repose in retirement, she will doubtless return with renewed strength to the discharge of her duties at the fitting time. Meanwhile the people of this country should understand that wearing a crown or wielding a sceptre is no child's play, even with a Constitutional Government.

AN UNDOUBTED LUNATIC SENTENCED TO BE HANGED.

HENRY WESTBY, the youth, aged eighteen, who was sentenced to death at Nottingham on February 1st for the murder of his father and of a fellow-clerk named Onions, is beyond medical question insane. Evidence to that effect was given in court, but the jury, following the direction of Mr. Justice Hawkins, disregarded it, considering only the stereotyped formula—if a man knows that he is taking life, and that by so doing he is breaking the law, he is sane, and therefore guilty. Upon this principle, the utter fallacy of which we have recently exposed, Westby is condemned. The legal situation is peculiarly embarrassing. If the Home Secretary yields to the remonstrance we now address to him, he will virtually yield the point of law, because without yielding that point Westby must be hanged. It is not likely Mr. Justice Hawkins will support the view we take, for it is directly opposed to his own. Westby suffered from the mania of suspicion, which rapidly developed a desire to kill those whom he suspected. The suspicion came first and the homicidal desire—we will not say impulse—came afterwards. Westby deliberately murdered his fellow-clerk Onions because he teased him, and he deliberately murdered his own father because he had corrected him. The young man knew what he was doing, and he was perfectly well aware that it was wrong. Nevertheless, he did it, and did it wholly and solely because he was insane. The only motive was an insane idea. The law refuses to accept the hypothesis of insane ideation as an explanation of conscious wrong-doing. It assumes that the authority of law is necessarily so high in the estimation of all minds, that to *know* its bidding implies a willingness to obey it, unless the law-breaker has a simply *criminal* intent. The absurdity of this position does not strike the legal mind. It cannot conceive of the existence of a mind so overborne by its inner morbid experiences as to take an insane view of the law itself, and to revolt against the restraint of a law which prohibits murder as a means of ridding the mind of a supposed tormentor. In short, the law has no cognisance of anything beyond the limits of its purview, and this is rigidly bounded, not by facts, but by the *legal* notion of facts. We confess that the way out of this difficulty as to the fate of the prisoner Westby is not plain to us. It seems a farce, to ask the Home Secretary to set aside the decree of a court in which the rule of procedure has been as clearly laid down as Mr. Justice Hawkins laid it down in this case. Perhaps it will be easier, on the whole, to let Westby be hanged, than to find a way out of the difficulty. The wretched young man desires to die. The court directed the jury, so that they could not—seeing that they lacked the moral courage to disregard the dictum of the judge, and obey the dictates of common sense—do otherwise than bring the prisoner in guilty. We are not about to plead for the life of Westby. We simply affirm that it will be a case of judicial murder if he be hanged. It is not our habit to "take up" cases of this class. We have refused to do so in instances of *doubt* which have been pressed on our consideration. There is no doubt, or room for question, in this instance. Westby is a lunatic, and he has been sentenced to be hanged. Will the sentence be carried out?

THE DESTRUCTION OF FERMENTS IN THE ALIMENTARY CANAL.

IN an article contributed to Foster's *Journal of Physiology*, Mr. J. N. Langley points out that, whilst it is well known that the saliva and gastric and pancreatic fluids, which are all discharged into the alimentary canal, contain a considerable amount either of amylolytic or proteolytic ferment, very little is known in regard to the fate of these ferments. A little of each is found in the fæces, a small quantity also in the urine; but these, taken together, make but a small fraction of the total amount which is received by the alimentary canal during digestion. He has undertaken a series of experiments to elucidate this point, and the results of these experiments appear to prove that the amylolytic ferment secreted by the salivary glands is destroyed by the hydrochloric acid of the gastric juice, that the proteolytic and rennet ferments secreted by the gastric glands are destroyed by the alkaline salts of the pancreatic and intestinal juices and by trypsin, and that the proteolytic and amylolytic ferments secreted by the pancreas are not improbably destroyed in the large intestine by the acids there formed. Mr. Langley found that a percentage of hydrochloric acid not exceeding 14 parts in 100,000 is sufficient at a tempera-

ture of 39° C. to destroy almost all trace of ptyalin in the course of five minutes, and that practically there is no conversion of starch into sugar in the stomach. In like manner, a pepsin solution warmed for twenty minutes with a 1 per cent. solution of sodium carbonate fails entirely to act on fibrin, and the addition of trypsin also diminishes the activity of pepsin. Trypsin itself is destroyed by acid and also by pepsin. This is a point of considerable importance, for if the pancreatic ferment be rapidly destroyed in the stomach, the question arises, Of what value are the pancreatic extracts that are so frequently ordered and taken? Further, Mr. Langley remarks, it cannot be much more advantageous to give zymogen than to give trypsin; for, supposing for a moment that the zymogen is not split up in the stomach into trypsin, how can it be split up in the small intestine, where the alkaline solutions tend to keep it intact?

VIVISECTION PASTIMES.

IF it be "cruel" to perform vivisection for scientific purposes, what can be said of the practice of vivisecting animals for mere pastime? This is what is done by pigeon shooters with their fair patronesses, by the hunters of tame stags, by the slaughterers of barn-door fed pheasants, and other devotees of what modern society calls "sport." It is little use to call attention to this matter, but we are reminded of the serious question involved by the "sportsman's exhibition" now on view. In so far as sport is *sport* in a true sense, there is nothing to be said against it; but very little of that which goes by the name fulfils the conditions. By-and-by the humane instinct may possibly revive, and we shall feel humiliated by the reflection that during the middle and towards the close of the nineteenth century the so-called "sport" of Englishmen and Englishwomen consisted mainly in torturing and killing by divers foul means poor little birds and tame game, and in hunting stags kept for the purpose of being hunted, and carted to and from the place of torture at the pleasure of those gentlemen and ladies who under Royal patronage habitually engaged in the sport. How different all this from the sport of old times, when those who hunted or shot first found their quarry and then pursued it! Then the pleasure was in the chase, now it is chiefly in the slaughter.

A HUNDRED YEARS AGO.

AN interesting memento of the scientific labours of a past generation has just come into the keeping of the Royal Medical and Chirurgical Society. It consists of the minute-book and proceedings, in manuscript, of a medical society founded about twenty years before the Medico-Chirurgical, which has long survived it; and it has been presented to the library of the latter by Mr. Charles Hawkins. The book itself has a history, having been in the possession of Sir Benjamin Brodie, whose son gave it to Mr. Hawkins. The Society was founded in 1783, and several interesting particulars concerning it were supplied by Mr. Hawkins in the letter he sent to the President (Dr. Barclay) accompanying the gift. It is mentioned by Sir B. Brodie in his Autobiography, and it published four volumes of Transactions. John Hunter appears to have been one of its founders; for about the time of its formation he wrote to Edward Jenner informing him of the fact, and asking the latter to transmit there his paper on "Tartar Emetic." That paper was read in June, 1784, and appears in the first volume of the Transactions, which was published in 1793. The first paper in the volumes is by Dr. Fordyce; the last by John Hunter, whose attendance at the meetings was continued to within three months of his death. Mr. Hawkins notes that Hunter never put "Surgeon to St. George's Hospital" after his name at the head of his contributions. The manuscript volume contains the autographs of the members and a letter from Hunter, and Mr. Hawkins mentions, as evidence of the patriotism of its members, a minute in 1798, to the effect that owing to "so much joy about Sir Horatio Nelson's victory no business was done." It was also, Mr. Hawkins goes on to say, a jealous society, for it is recorded that Dr. Crozier was not elected a member because he was secretary to a volume issued by another society, and styled the "Medico-Chirurgical Transactions." The illustrious members of that select circle could not have foreseen the day when their own "Proceedings" would fall into the possession of their (then young) rival, and be regarded almost with antiquarian curiosity. The Fellows of the Royal Medical and Chirurgical Society may, when they learn this, perhaps, feel inclined to think of the words—*absit omen*; although we believe that there is little indication within the Society itself of approaching dissolution. To judge from the increasing number of candidates for its fellowship, the attendance at the meetings and the papers on the list awaiting to be read, the Society is showing a vitality in favourable contrast with its condition not many years since.

INFLUENCE OF FOG ON THE LONDON DEATH-RATE.

IT is now, fortunately, very rarely that the metropolitan death-rate reaches the high figure 35·3, which was recorded in the week ending 11th inst. It is not difficult to assign the recent dense fogs as the main cause of this excessive mortality, more especially as the only weeks in which similarly high death-rates in London have been recorded during recent years were those ending 20th December, 1873, and 7th February, 1880, each of which immediately followed a period of dense fog and intense cold. In the twenty-seven large provincial towns now dealt with in the Registrar-General's Weekly Return, the death-rate in the week ending 11th instant did not exceed 25·2 per 1000, and was 10·1 below the metropolitan rate during the same week. It is evident, therefore, that this remarkable excess in the London death-rate was due rather to the fog than to the temperature, which, although below the average, was but a moderately cold winter temperature, and was no lower in London than in the provinces. The exceptional fatality of whooping-cough, which caused no fewer than 261 deaths in London during last week, showed an increase upon that recorded in the first week of February, 1880, when, under the influence of cold and fog, the death-rate from this disease was stated by the Registrar-General to be higher than any rate previously on record.

HYALINE TUBERCLE.

IN a lecture on Miliary Tubercle given before the Vienna Medical Society, Dr. Chiari pointed out how considerable has been recent progress in the histology of tubercle, since we now recognise as such not only that which consists exclusively of round cells, large and small, but also miliary tubercles which possess a strongly developed reticulum, in the meshes of which so-called epithelioid cells lie, and also varieties with a distinct fibrous connective tissue. Hence the histological distinction into lymphoid, reticular, and fibrous tubercles. All three forms ordinarily contain some giant cells, and all exhibit a progressive caseation extending from the centre to the circumference. There are, however, certain exceptions to this usual tendency to caseation. Some miliary tubercles present a peculiar hyaline transformation. This change was first observed in the miliary tubercle from the liver of a child aged four years and a half. The tubercles in the brain, lungs, and bronchial glands, in the same case, presented the ordinary aspect of

lymphoid tubercle. The clear hyaline aspect of those in the liver gave them a very peculiar appearance. It is believed to depend on a hyaline degeneration of the reticulum, and resembles most closely the hyaline degeneration of the capillaries of the brain. Dr. Chiari conjectures that it may be regarded as a benign change, opposed to the caseation which tends to infection.

THE QUEEN'S VISIT TO THE RIVIERA.

THERE ought to be—and probably there is—no occasion for anxiety as to the safety of the Queen during her sojourn on the Continent. It is, however, impossible to dismiss a fear lest certain of the multitudinous risks of infection, which are concomitants of those inveterate habits of uncleanliness, and that supercilious contempt for the penalties of filth, which prevail among foreigners and are painfully known to flourish in the Riviera, should be overlooked. At the peril of seeming to meddle where no need of meddling exists, we venture to urge that more than common precaution should be taken to ensure immunity from the dangers of diphtheria, typhoid fever, and other communicable maladies. It is a mischievous practice to overhaul the drains of an old building such as a palace or château immediately before a family comes into residence. Dr. William Budd, who knew more about fever than any living member of our profession, used to lay the greatest stress on the danger of disturbing old accumulations of possibly infected soil. It is like the turning up of ground wherein the seeds of noxious growths lie inert because they chance to be buried too deeply to germinate. When brought near to the surface they burst into activity. It would be well to avoid localities which are likely to be infected, and to refrain from disturbance of any kind in the neighbourhood where Her Majesty proposes to sojourn.

EXACTING "MEDICAL FEES" AT POLICE STATIONS.

IT has come to light, in connexion with a case of alleged drunkenness which came before Mr. Ellison at the Lambeth Police Court a few days ago, that police inspectors demand the fee for a "doctor" before they call in the police surgeon to persons who are charged with drunkenness, but who deny the imputation and require to see a medical officer. If the fee is not forthcoming the police surgeon is not sent for. This is a monstrous abuse of authority, and should at once be prohibited. No inspector should have the right to refuse a request for medical attendance. If the case turn out to be one of imposture, the fee might be added to the fine imposed; otherwise it might be a charge on the police rates. We trust this case will be the last of the kind which is permitted to occur. Mr. Ellison did not characterise the practice too strongly when he described it as "a foul and shameful imposition."

THE COMPOSITION OF HUMAN FAT.

DR. LEBEDEFF of Moscow has contributed a short memoir to Hoppe-Seyler's *Zeitschrift für Physiologische Chemie*, on the subject of the metabolism of fat in the body, in the course of which he takes occasion to give the results of his observation on the composition of human fat, a point that, singularly enough, does not appear to have received attention from any observer. Chevreul indeed examined the melting-point of the fat of man, and found the panniculus adiposus melted at from 20° to 22° C., and set or solidified at from 12° to 15° C., and Lerch noticed that capronic acid existed in human fat, but there are very few, if any, other observations. Lebedeff states that fat from various regions of the body presents differences, but they are only slight in degree. Its colour is yellowish or brownish. At ordinary temperatures it is rather hard, or semi-solid, and destitute of smell. It dissolves with difficulty in cold alcohol. Its specific gravity is always less than 1°. The fat obtained from the subcutaneous connective tissue contained in one case 80 per cent. of oleic acid, and 16·7 per cent. of solid acids—i.e., palmitic and stearic acids; in another case 78·6 per cent. of the former and 14·7 of the latter acid. Fat from the abdomen contained in one case 74·4 per cent. of oleic acid, and 22 per cent. of palmitic and stearic acids, in a second 76·6 per cent. of oleic acid, and 20·9 per cent. of palmitic and stearic acids.

UNQUALIFIED ASSISTANTS.

AT an inquest held in Dairycoates, near Hull, the undesirability of employing unqualified assistants was lately brought very prominently forward. It seems that two little girls, named Stevenson, died suddenly at Dairycoates with all the symptoms of irritant poisoning. They were seen in the first instance by the unqualified assistant of Dr. Jackson, of Boulevard, who prescribed some bromide of potassium in a mixture. They were seen the next morning by Dr. Jackson himself, who at once suspected irritant poisoning, but all treatment was unavailing and the children rapidly sank. The stomachs of the deceased presented signs of irritant poisoning, but analysis failed to discover any poison, either in the stomach of the deceased or in the food or medicine administered to them. The source of the poison remains doubtful, but the occurrence of similar troubles in other children living in the immediate vicinity and the discovery of very imperfect sewers make it possible that sewer gas was the cause of the mischief, a theory put forward by Dr. Jackson at the inquest. In spite of the fact that the medical attendants of the deceased were in no wise answerable for the fatal result the coroner made an unjustifiable attack upon Dr. Jackson and his unqualified assistant. As to the (to say the least) unadvisability of employing unqualified assistants there can be no doubt; but there can also be no doubt that the coroner's remarks on the occasion in question were uncalled for. A coroner's duty is to discover the cause of death, and although there was not one tittle of evidence to implicate either Dr. Jackson or his assistant, the jury, encouraged by the coroner, appended to their verdict a censure on the relationship existing between Dr. Jackson and his assistant, a censure which, whether deserved or not, was clearly in this case decidedly *malapropos*.

"THE INFLUENCE OF VIVISECTION ON HUMAN SURGERY."

TO those who are interested, whether as advocates or opponents, in the question of experimentation upon living animals, we cordially recommend the interesting address on "The Influence of Vivisection on Human Surgery," delivered on the 9th inst. by Mr. Sampson Gamgee in the Birmingham Medical Institute. By taking a broad though rapid survey of the history of surgery, Mr. Gamgee has been enabled to collect an enormous mass of facts illustrating the direct indebtedness of scientific surgery to experiments performed upon the lower animals. Among the bequests of vivisection to surgery, he enumerates the ligature of bleeding arteries, trephining the skull, amputation of the hip, the Hunterian operation for the cure of aneurism, transfusion, and the surgical treatment of diseases and injuries of the abdominal viscera. By these proceedings thousands of human lives have been already prolonged, at no greater sacrifice than an inconsiderable amount of suffering to the lower animals. It is difficult to believe that those who offer an unqualified opposition to all vivisectional experimentation have made themselves acquainted

with its scope and character. Honest inquirers will find instruction and enlightenment in Mr. Gamgee's address, while the faithful have supplied to their hand the grounds of the belief that is in them.

ISOLATION OF CASES OF DIPHTHERIA.

THE medical officer of health for St. Pancras, Mr. Shirley F. Murphy, at the request of his Vestry, has been instituting an inquiry among the medical officers of health of metropolitan sanitary districts as to the necessity for the isolation of persons suffering from diphtheria, and the propriety of treating such cases among the non-infectious patients in general hospitals. Of thirty circulars of inquiry issued, and to which twenty-seven replies were received, one only approved of the treatment of the disease with non-infectious patients; but this reply was accompanied by conditions which were equivalent to a statement that the disease ought to be treated apart, for, it added, if the disease were "not epidemic," and a certain state of cubic space could be obtained, &c. It may be taken that the medical officers of health of the metropolis are almost, without exception, of opinion that diphtheria as a disease should in treatment be isolated from other diseases. It is remarkable that diphtheria rarely comes to the knowledge of sanitary officers in London, except in cases of death, and that one medical officer did not know of the existence and advantages to be derived from the London Fever Hospital. Let us hope that no part of the pecuniary difficulties of that invaluable institution arises from ignorance, assumed or actual, of the medical profession.

CHOLERA.

SUNDRY reports have gained currency of late of cholera having made its appearance in Egypt. These reports seem to be wholly without foundation. The latest trustworthy reports we have at hand speak of the cessation of the disease at Mecca, at Medina, at Jedda, and at Yembo, while at the quarantine station of El Wedj the occurrence of cases was few and far between. Northward of El Wedj no cases of cholera have been observed, and there does not appear to have been noticed any tendency to extension of the disease beyond that point. A connected history of this spread of cholera in Western Arabia has not yet been published, nor of its relations with the outbreak of cholera at Aden which preceded it. The Egyptian sanitary authorities are very wroth with the course pursued by the responsible authorities at Aden when first cholera appeared at that station. A month was allowed to elapse before any knowledge of this was given to Egypt, and meanwhile the disease had shown itself among the pilgrims at Mecca. In consequence of this unaccountable neglect of the Aden authorities the Egyptian sanitary authorities have become so distrustful of the Indian authorities generally that they have practically declared quarantine against ships coming from Indian ports, and so interposed a serious check upon Indian maritime commerce, further complicating a hitherto sufficiently complicated question—namely, that of quarantine in the Red Sea.

UNIVERSITY COLLEGE HOSPITAL.

ON Wednesday the annual festival dinner of the hospital was held at the Langham Hotel, under the presidency of H.R.H. the Duke of Cambridge. Some pertinent remarks were made by his Royal Highness and by the Earl of Kimberley on hospital management. Suggestions were thrown out as to the desirability of compelling a more widespread, and even a compulsory, support of the great medical charities, though no precise scheme was proposed as to the way in which this should be accomplished.

TOXIC ACTION OF SALIVA.

M. GRIFFINI has undertaken to repeat the experiments of MM. Pasteur and Vulpian on the toxic action of saliva injected under the skin, and has communicated an article on the subject to the *Archivio per le Scienze Mediche*, t. v. He obtained both pure parotidean and mixed saliva, and injected both fluids beneath the skin in rabbits. He believes that pure parotidean saliva is perfectly inoffensive, that ordinary mixed saliva filtered through porous plates, so as completely to prevent the passage of microbia, does not produce any local gangrenous changes, but a general infection of the blood, resembling in all essential respects septicæmia. He has satisfied himself that it is the saliva, and not the microbia that it contains, which produces the septicæmic condition. Mixed unfiltered saliva contains much more toxic constituents, due probably to commencing putrefaction or to fermentation in the buccal cavity; hence, when this is subcutaneously injected, gangrenous complications occur with necrosis of the tissues and ordinary septic accidents due to the resorption of gangrenous products. M. Griffini considers that his experiments prove that the toxic action of saliva is due to a non-organised ferment.

THE DUCHESS OF CONNAUGHT.

WE understand that the Duchess of Connaught continues to make very satisfactory progress. The removal from Bagshot has had a most beneficial effect on her condition: all the symptoms, which at one time promised to be very serious, have passed away, and, although weak, she may be said to be convalescent. There is no foundation whatever for the rumour that the Duke of Connaught has had a threatening of typhoid. His Royal Highness is, we believe, in perfect health.

SEATS FOR OMNIBUS CONDUCTORS.

THERE is no reason why omnibus conductors should not be provided with seats, except the need that they should be always on the alert, and the fear that if allowed to sit they would quickly fall asleep, thus neglecting their business, and cutting off communication between passengers and the driver. We have not yet arrived at the high pitch of civilisation which would suggest the convenience of a bell-pull suspended from the roof of every omnibus by which to call the attention of the driver. We recognise the "objections" to giving the conductors of omnibuses seats; but clearly they are not of a nature to be regarded as insuperable. It is not necessary to provide too comfortable lounges. A small perch, such as that enjoyed by the driver of a hansom cab, would suffice. The object should be, to afford relief from the standing posture, which, being continuously preserved from morning to night, gives rise to many evils and much suffering.

THE NAPPER TESTIMONIAL.

WE print in another column the circular letter recently published by the Provisional Committee of the Napper Testimonial Fund. When the movement was first started we expressed our assurance of the cordial and generous support which we felt convinced it would receive, and deservedly, from the profession and public at large. Indeed, when the excellent and widespread results of Mr. Albert Napper's long-continued and devoted services to the cottage hospital system, which he inaugurated as early as 1859, are remembered, there is good reason to anticipate that success will attend the efforts of the Committee. We understand a public meeting will shortly be held to elect a permanent committee, and to consider the form the testimonial should take.

TYPHOID IN EDINBURGH.

THE recent occurrence of typhoid in Edinburgh has been made the subject of inquiry by Dr. Littlejohn. One hundred cases, and the circumstances attending them, were ascertained. The houses where they occurred were all visited, and in the majority of instances the sanitary arrangements examined. The source of milk supply has also been traced, and the larger number of dairies visited. The sanitary arrangements of the houses were, as a rule, found good; but as the milk-supply of most of the infected families in the southern suburbs, and a few of those in the St. Leonard's district, was found to be obtained from one dairy, the issue of milk from this dairy was stopped. The outbreak attained its most serious proportions about the 19th ult. Since then it has gradually declined, and now appears to have ended. Of the cases examined, 10 occurred in the New Town, 50 in the Old Town, 40 in the southern suburbs, and 37 in the St. Leonard's district.

A BILL TO SHORTEN THE HOURS OF LABOUR IN RETAIL SHOPS.

LORD STANHOPE has introduced a Bill in the House of Lords to limit the time of labour in shops and warehouses of the drapery class to ten hours daily. There are special provisions for extension of time by licence to be given by the Home Secretary on particular occasions. Surely ten hours a day is long enough for any shop to be open. Little or no business is done before nine o'clock in the morning, or after seven o'clock in the evening. We should have preferred to limit the hours to nine; but the length of day proposed is ample for all legitimate trade purposes. Lord Stanhope would enhance the value of his Bill if he added a clause requiring the provision of seats for servers. If the promoter of the new measure will not consent to make this addition, it should be moved as an amendment.

THE UNIVERSITY OF ABERDEEN.

THE Sir Erasmus Wilson's Chair of Pathological Anatomy has now been founded and endowed. The deed has been communicated to the Home Office, and the endowment of £10,000 has been received by the university. Sir Erasmus has nominated the Crown as patron of the chair. The professor will receive as salary the free yearly revenue of the endowment, in addition to the fees; he is not to engage in private practice, but must devote his whole time to the duties of the chair.

PLAGUE.

A TELEGRAM from Teheran, dated Feb. 14th, announces the appearance of a disease resembling plague at a small village in the neighbourhood of So-uj-Bolak, on the 8th inst., since which date upwards of forty fatal cases have occurred. The district of So-uj-Bolak was the scene of an outbreak of plague in 1870–71. A later telegram reports the disappearance of the plague-like affection. It is also reported that the present winter in Persia is exceptionally rigorous, the thermometer registering at the time of the telegram 35° F. of frost.

THE THAMES SEWAGE OUTFALLS.

A COMMUNICATION from the City of London Corporation and a deputation from the Woolwich Sanitary Authority have, the one been addressed to, and the other waited upon, the Home Secretary with reference to the pollution of the Thames at the main-sewerage outfalls at Barking and Crossness. The Home Secretary has promised attention to the statements made to him, and no doubt their representations will lead to further inquiry.

CRICKET.

IN an interesting lecture, given by Mr. Frederick Gale on the 13th inst. at the Marlborough Rooms, a remarkable instance was given of the longevity of cricketers. This was the so-called B Eleven, chosen by Lord Frederick Beauclerk to play against All England. Of these eleven men the youngest died at the age of sixty-nine, while the others succumbed between that age and ninety-five. The lecturer might well say that insurance offices would grow rich if no lives but those of cricketers were taken. Mr. Gale is well known as an enthusiastic cricketer; and there was a wholesome, honest ring in his lively and interesting discourse, which his audience (a large and influential one) evidently appreciated. Professor Ruskin occupied the chair. The importance of cricket upon the health and stamina of the nation cannot be over-estimated; and we trust that enthusiasts like Mr. Gale may never be wanting to stir up the rising generation to honourable deeds in the "field," where, according to the Iron Duke, the Battle of Waterloo was won.

MEASLES AT WOLVERHAMPTON: CLOSURE OF TWO BOARD SCHOOLS.

AN epidemic of measles has lately broken out in two of the Board schools at Wolverhampton. The attention of the medical officer of health having been drawn to the outbreak, he advised the temporary closure of both schools. The School Board, being unwilling to act upon this advice, sent a deputation to consult the Sanitary Committee of the borough upon the best course to be adopted under the circumstances. The medical members of the committee supported the opinion of the medical officer, but simply as a suggestion, the sanitary committee having no legal power to enforce their recommendation. The School Board have since decided to close both schools.

MEETINGS of the Royal Commission on Small-pox and Fever Hospitals were held at No. 10 Committee-room, House of Commons, on the 10th, 11th, and 14th inst. There were present at the meetings—Lord Blachford, Sir James Paget, Sir Rutherford Alcock, Mr. A. W. Peel, M.P., Mr. E. L. Pemberton, M.P., Dr. A. Carpenter, Dr. J. Burdon Sanderson, Dr. W. H. Broadbent, Mr. Jonathan Hutchinson, and the secretary, Mr. Nathaniel Baker.

A BUST of the late Dr. Robert Smith, Professor of Surgery in the University of Dublin, and for many years Honorary Secretary of the Dublin Pathological Society, has been executed at the cost of the members of that Society, and presented by them to the Royal College of Surgeons in Ireland, where it has been placed amongst the series of busts of distinguished Irish surgeons which decorate the Hall of that College.

THE Law Committee of the Aberdeen University have recommended that the subjects of examination for the medical bursaries under the Council's patronage should cease to be optional, and should consist of physics, natural history, botany, and inorganic chemistry, a definite value to be fixed to each subject. The recommendation has been approved.

MR. THOMAS BOND, M.B. Lond., F.R.C.S. Eng., of the Westminster Hospital, has been elected medical officer to the Great Western Railway Company.

THE members of the "medical profession" held their first annual dinner at the North-West Provinces' Club House, Allahabad, on Feb. 2nd.

WE understand that the ensuing number of the *Nineteenth Century* will contain an important paper by Professor George Fleming on the Influence of Vivisectional Experiments on the Treatment of Diseases of the Lower Animals.

THE death is announced of Deputy Inspector-General James Jopp, half-pay, Army Medical Department. Mr. Jopp served for many years in the 36th Regiment, and retired on half-pay in 1864.

DR. THOMAS K. CHAMBERS has been elected to represent Oxford University in the General Council of Medical Education and Registration in the United Kingdom for five years, in place of the late Professor Rolleston.

PROFESSOR FREUND, of Strasbourg, is reported to have been offered and to have accepted the chair of Obstetrics in Breslau, formerly occupied by the late Professor Spiegelberg.

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

Reading (*Urban*).—Dr. Shea has to report for 1881 for this borough the lowest rate of mortality both from all causes and from zymotic diseases since his appointment as medical officer of health. The general death-rate, estimated on a population of 42,330 persons, was 14·1 per 1000; the zymotic death-rate 0·82 per 1000; and the birth-rate 34·8 per 1000. "The reduced death-rate," Dr. Shea remarks, "was chiefly due to the absence of fatal zymotic cases during the past year, and as some of the enteric fever cases were due to infection contracted by persons while away from Reading, the disease developing shortly after their return, the absence of fatal zymotic cases due to the borough might be put in a still more favourable light if these were excluded." The mortality among infants was also exceptionally low during the past year. Small-pox was introduced into the borough three times in 1881, but in each case the disease was at once isolated in the hut hospital retained for the purpose, and the disease was limited to the single case. Other zymotic diseases presented nothing for particular remark; but of the hut hospital above referred to it is said that during the year it has been improved by the addition of a disinfecting chamber and a mortuary, and that a suitable ambulance waggon and shed have been supplied to it. There has been no decrease in the number of new buildings added to the borough during the year, and careful attention appears to have been given to their drainage connexions, and generally to the sanitary condition of the place. A Local Act of last session gave the Corporation powers with regard to the compulsory notification of disease, and this provision of the Act Dr. Shea tells us is working well.

Hampstead (*Metropolis*).—Dr. Gwynn has published a memorandum on the prevalence of small-pox in the parish of Hampstead during recent epidemics of the disease in the metropolis. During the epidemic of 1870–72, 162 cases were sent from the parish into the Hampstead Small-pox Hospital, 40 of these cases coming from a radius of a quarter of a mile from the centre of the Hampstead Hospital. During the epidemic of 1876–78, 110 cases were sent from the parish into the hospital, of which 44 came from streets in the vicinity of the hospital, and 51 from the district within a radius of a quarter of a mile from the centre of the grounds of the hospital. During the epidemic of 1880–81, the total number of cases reported in the parish, including those occurring in private houses, was 50. Comparing the mortality from small-pox in Hampstead with the mortality from the disease in London generally, Dr. Gwynn shows that it was in the parish of Hampstead per 1000 total deaths of small-pox in London, in 1871–72, 3·3; in 1876 to 1878, 7·4, during which periods the Hampstead Small-pox Hospital was open; and in 1880–81, when the hospital was closed, 2·1. "We are obliged, therefore, to inquire," writes Dr. Gwynn, "what special cause existed in the two former epidemics that injuriously affected the neighbourhood of Fleet-road and adjacent parts, which is not existing at the present time. The opening of the Hampstead Small-pox Hospital for the reception of small-pox cases during the two epidemics can, I think, be the only reasonable cause offered." But how comes Dr. Gwynn to omit the fact that the epidemic in 1870–72 of small-pox had broken out on Haverstock-hill and among the streets intervening between that hill and Fleet-road before a single small-pox patient was admitted into the Hampstead hospital?

Newbiggin-by-Sea (*Urban*).—Dr. J. C. Reid sends us an account of an outbreak of small-pox in severe form in this district. He experienced some difficulty in inducing school-managers to believe that teachers coming from houses infected with the disease could not safely mingle with the scholars.

Belfast.—During January 105 cases of small-pox were removed to the hospital for contagious diseases, and every precaution taken to prevent the spread of infection. The total births registered amounted to 527, and the deaths to 434, of which 60 were due to phthisis, and 106 to diseases of the respiratory organs, making a total of 166 deaths from lung affections. During the four weeks the small-pox epidemic numbered some 15 cases more than occurred in the month of December, the mortality amounting to 21, or at the rate of 1·3 per 1000, being an increase of 9 deaths as compared with the previous month. This increase is not remarkable, when we consider the large number of persons among the working classes who have been imperfectly vaccinated or not vaccinated at all in childhood, or who have not been submitted to revaccination when requisite. In two previous reports Dr. Browne, medical superintendent officer of health, drew attention to the serious evils which arise from the unguarded intercommunication that constantly takes place between healthy persons and those who are, or have recently been, suffering from any infectious disorder, and the sanitary authority lately had notices largely issued calling attention to this important matter.

SMALL-POX IN THE UNITED STATES.

The twenty-ninth bulletin of the National Board of Health, in view of the prevalence of small-pox in the United States, gives a list of nine farms from which animal vaccine lymph can be obtained.

The Merthyr Local Board has been in communication with the Local Government Board, on the necessity of closing schools in face of an epidemic of scarlet fever. The Local Government Board approves of a recommendation to this effect, as suggested by the medical officer of the Local Board, but the Local Board appear to have been taking objections on the ground that they have no power themselves of closing the schools. The Local Government Board, however, gives little heed to this objection, holding, no doubt rightly, that few schools would set themselves in opposition to a deliberately expressed recommendation of the sanitary authority.

The Nottingham Town Council have passed a resolution, that the section of the Local Improvement Act, 1878, as to the notification of infectious diseases, shall be put in force in respect to small-pox and scarlet fever. Experience has amply shown that until the compulsory powers of the Act are brought into force, the information communicated to the sanitary officers on the occurrence of these diseases is not sufficient to meet the public health necessities of the borough.

At a recent meeting of the Lancashire and Cheshire branch of the British Medical Association, the following resolution, moved by Dr. Leslie Jones, seconded by Dr. Ransome, and supported by Dr. W. Roberts, was adopted:—"That in the opinion of this meeting compulsory notification of infectious diseases is of great public and national importance, and that in carrying out that object the meeting believes that the responsibility of notifying should rest with the householder."

Indications are being given of a wider distribution of small-pox in the kingdom. Instances of the disease have been recorded at Bedford, Northampton, Irchester, Huntingdon, and Ampthill.

A case was recently heard before the Cardiff magistrates in which evidence was tendered of the dangerous pollution of the water of a particular well, and an order was requested for its closure. Evidence was, however, tendered against the issue of the order, by persons who had lived long on premises supplied with water from the well, and the case was adjourned that the proprietor might obtain legal advice.

An effort has been made in a court of law to restrain the Local Government Board from dismissing Dr. Donahoo from the post of district medical officer in St. Saviour's parish, south of the Thames. The court held, however, that the dismissal was absolutely in the discretion of the defendants.

At a recent meeting of the Bedminster Board of Guardians, information was given of a patient suffering from scarlet fever who had left the hospital of the authority without leave, and gone to reside in the City of Bristol. It was decided to give the Bristol Sanitary Authority information of the occurrence.

The Romford Local Board have taken objection to the proposal of the Romford Rural Sanitary Authority to erect an infectious disease hospital in a field near the Romford Union house, and close to the town. The Local Government Board has been appealed to on the subject.

On the recommendation of the General Purposes Committee, the Local Board of East Moseley has declined to join the Kingston Rural Sanitary Authority in the proposed combination for the establishment of an infectious disease hospital.

A surgeon at Bolton, it is reported, has been fined £5 for neglecting to report a case of small-pox under the Bolton Improvement Act.

The latest report from Hull shows that the epidemic of scarlet fever is distinctly abating in that town.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In twenty-eight of the largest English towns, 6220 births and 4832 deaths were registered during the week ending the 11th inst. The annual death-rate in these towns, which had been equal to 22·6, 24·8, and 24·9 in the three preceding weeks, further rose last week, under the combined influence of fog and low temperature, to 29·8 The lowest rates in these towns last week were 19·4 in Derby and 21·0 in Leeds; whereas the rates in the other towns ranged upwards to 30·1 in Newcastle-upon-Tyne, 30·2 in Oldham, 32·2 in Manchester, 34·8 in Blackburn, and 35·3 in London. The deaths referred to the principal zymotic diseases were 678 in the twenty-eight towns last week, showing a further increase upon recent weekly numbers; 336 resulted from whooping-cough, 117 from measles, 93 from scarlet fever, 53 from "fever" (principally enteric), 31 from diarrhœa, 27 from diphtheria, and 21 from small-pox. No death was referred to any of these diseases last week in Derby; while they caused the highest death-rates in Brighton and Blackburn. Whooping-cough showed the largest proportional fatality last week in London, Wolverhampton, and Huddersfield; measles in Blackburn, Norwich, and Brighton; scarlet fever in Hull and Brighton; and fever in Blackburn. The 27 deaths referred to diphtheria included 16 in London, 4 in Portsmouth, and 3 in Manchester. Small-pox caused 24 more deaths in London and its suburban districts, 2 in Bolton, one in Nottingham, and one in Hull. The number of small-pox cases in the metropolitan asylum hospitals had further declined to 473 on Saturday last; these included 45 in the convalescent hospital at Darenth. The new cases of small-pox admitted to these hospitals were 78 last week, against 80 and 81 in the two preceding weeks. The deaths referred to the respiratory diseases in London, which had been 415, 543, and 647 in the three previous weeks, further rose to 994 last week, and exceeded the corrected weekly average by 427. The causes of 106, or 2·2 per cent., of the deaths in the twenty-eight towns last week were not certified either by a registered medical practitioner or by a coroner. The proportion of uncertified deaths did not exceed 1·3 per cent. in London, whereas it averaged 3·3 in the twenty-seven provincial towns. All the causes of death were duly certified in Brighton, Derby, Birkenhead, and Cardiff; while the proportions of uncertified deaths were largest in Oldham, Salford, and Sunderland.

HEALTH OF SCOTCH TOWNS.

The annual death-rate in the eight Scotch towns, which had been equal to 22·6 and 21·1 per 1000 in the two preceding weeks, rose to 24·7 in the week ending the 11th inst., but was no less than 5·1 below the average rate in the twenty-eight large English towns. The deaths referred to the principal zymotic diseases in these Scotch towns, which had been 90 and 76 in the two previous weeks, rose to 104 last week; of these, 24 resulted from diphtheria, 22 from whooping-cough, 20 from "fever," 18 from diarrhœa, 12 from measles, 8 from scarlet fever, and not one from small-pox. The annual death-rate from these zymotic diseases was equal to 4·4 per 1000 in the eight towns, and ranged upwards from 1·3 in Edinburgh, to 9·6 in Leith and 12·0 in Perth. The 24 deaths from diphtheria showed an increase of 10 upon the number in the previous week; 17 occurred in Glasgow, 2 in Dundee, and 2 in Aberdeen. The 22 fatal cases of whooping-cough showed a further slight increase upon recent weekly numbers, and included 15 in Glasgow. The 20 deaths from "fever" also exceeded recent weekly numbers; 9 were returned in Glasgow, 3 in Edinburgh, and 5 in Leith. Fever fatality last week was nearly three times as great in these Scotch towns as in the twenty-eight English towns. The 18 deaths attributed to diarrhœa were also excessive, and included 5 in Glasgow, 5 in Leith, and 4 in Dundee. Of the 12 fatal cases of measles 8 occurred in Glasgow and 3 in Perth; while 4 of those of scarlet fever were returned in Glasgow. The deaths attributed to acute diseases of the lungs, which had been 101 and 120 in the two previous weeks, further rose to 137 last week, but were 63 below the number returned in the corresponding week of last year. The death-rate from these diseases differed but slightly from the average rate that prevailed in the English towns.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had been equal to 36·1 and 37·6 per 1000 in the two preceding weeks, declined to 33·6 in the week ending the 11th inst. During the first six weeks of the current year the death-rate averaged 35·4, against 26·6 in London, and but 19·3 in Edinburgh. The 224 deaths in Dublin showed a decline of 27 from the number in the previous week; 23 were referred to measles, 4 to "fever," 3 to diarrhœa, one to whooping-cough, and not one either to small-pox, scarlet fever, or diphtheria. The annual death-rate from these principal zymotic diseases was equal to 4·6 per 1000 in the city; the rate from the same diseases was equal to 5·1 in London and 1·3 in Edinburgh. The fatal cases of measles, which had been 47 and 39 in the two preceding weeks, further declined to 23 last week; they averaged no fewer than 36 in the first six weeks of this year. The 4 deaths from "fever" also showed a further slight decline from recent weekly numbers. The deaths of infants were more numerous than in recent weeks, while those of elderly persons showed a decline of but one.

THE SERVICES.

Surgeon-General J. S. Furlong, M.D., has been appointed by the War Office to be Principal Medical Officer to the forces in Ireland. Dr. Furlong, who served throughout the Crimea and Indian mutiny campaigns, has been recently serving as Principal Medical Officer in Canada.

Surgeon-Majors C. H. Browne, J. Williamson, Surgeons P. Hayes, P. J. James, and W. Donnovan are on passage from India in H.M. troopship *Malabar*, which left Bombay on Jan. 18th for Portsmouth.

Surgeon-Major R. Turner, A.M.D., has been granted six months' leave of absence from India on the recommendation of a Medical Board.

MILITIA MEDICAL DEPARTMENT.—Surgeon-Major Wm. McCheane, Royal Lancashire Artillery Militia, resigns his commission; also is permitted to retain his rank and to wear the prescribed uniform on his retirement.

RIFLE VOLUNTEERS.—4th Kent Corps: Surgeon Thomas Warner Lacey resigns his commission. — 4th Staffordshire Corps: Surgeon John Henry Love resigns his commission; also is permitted to retain his rank and to continue to wear the uniform of the corps on his retirement.—7th West Riding

of Yorkshire (Leeds) Corps: Surgeon Jas. S. Loe is granted the honorary rank of Surgeon-Major.

ADMIRALTY.—In accordance with the provisions of Her Majesty's Order in Council of April 1st, 1881, Fleet Surgeon Edward Mulcahy has been placed on the retired list of his rank from Feb. 10th, 1882.

WILLS AND BEQUESTS.

THE will of David Graham Miller, M.D., Fleet Surgeon R.N., of No. 113, Camberwell New-road, Kennington, who died on November 28th last, was proved on the 23rd ult. by Mr. George Henry Burnett, one of the executors, the value of the personal estate being over £18,000. The testator leaves to his wife, Mrs. Maria Miller, his household furniture and effects and an annuity of £42 for life or widowhood; to his son, William Graham Miller, £7000, two houses in Orkney, and a further sum of £500 to complete his education for the ministry; to his daughter, Euphan Graham Miller, £4000; to his daughter Mrs. Martha Caldwell, his Queensland debentures, in addition to what he settled on her at her marriage; and the residue of his property between his three children.

The will of Timothy Tudge, M.D., of Park Villa, Park-road, Yeovil, Somersetshire, who died on Sept. 25th last, was proved on the 2nd inst. by Mrs. Charlotte Tudge, the sole executrix, to whom he gives all his property, real and personal. The value of the personalty exceeds £1500.

The will of William Gwillim, M.D., of Burton-on-Trent, who died on Oct. 14th last, was proved on the 25th ult. by Miss Emma Waring Gwillim, the daughter and sole executrix, to whom, subject to a legacy of £100 to his married daughter, Mrs. Selina Waring Watson, he leaves all his property.

The following legacies have recently been left to hospitals and other medical charities:—Mrs. Mary Anne Smith, of 21, Russell-square, £5000 to the London Hospital; £500 each to the Scotch Hospital, Crane-court, Fleet-street, the Hospital for Diseases of the Chest, Victoria-park, and the Royal Free Hospital, Gray's-inn-road; £300 to the Royal Sea-bathing Infirmary, Margate; £100 to the London Truss Society; and £50 each to the Bloomsbury Dispensary and University College Hospital.

THE NAPPER TESTIMONIAL FUND.

THE following circular has been issued by the Provisional Committee of the fund:—

All who have been connected with a cottage hospital will recognise the great benefit its establishment has conferred upon the public and the medical profession. The first cottage hospital was founded by Mr. Albert Napper, M.R.C.S., the Rev. Canon and the late Mrs. Sapte, at Cranleigh, in Surrey, in the year 1859. As Mr. Napper not only took part in the foundation of this hospital, but by his writings, published in THE LANCET and in *Good Words*, and circulated amongst the profession privately, and by the invaluable aid he has always readily extended to everyone who desired to gain information upon the subject, greatly fostered the movement, he is clearly entitled to claim that he is, in the best sense of the word, the founder, and in fact the father, of the cottage hospital system. In the twenty-one years which have elapsed since the Cranleigh Cottage Hospital was opened, about three hundred others have been founded in various parts of the United Kingdom. The system has extended to the colonies, and has recently become popular in America. Mr. Albert Napper has lately retired from practice, and many members of the medical profession and others interested in cottage hospitals have thought the present a fitting opportunity for initiating a movement which will commemorate Mr. Napper's work in a substantial manner. With this object a Provisional Committee, consisting mainly of the medical officers of cottage hospitals situated in the counties of Sussex, Surrey, and Kent, was appointed at a meeting of the South-Eastern Branch of the British Medical Association held in Reigate on Oct. 20th, 1881. This Committee, after due deliberation, has decided to invite the co-operation of the medical officers of every cottage hospital, and of all others who are interested in their management and progress. A sub-committee, honorary secretaries, and treasurers have also been elected *pro tem.*, with the view of enlisting the support of all who are likely to be interested in this movement.

HENRY C. BURDETT,
CHARLES PARSONS,
J. HERBERT STOWERS,
} Hon. Secs.

23, Finsbury-circus, E.C.,
Feb. 11th, 1882.

Correspondence.

"Audi alteram partem."

FILARIA SANGUINIS HOMINIS AND FEVER

To the Editor of THE LANCET.

SIR,—Dr. Carter has asked me, through THE LANCET of Oct. 22nd, 1881, if I consider that the great abundance of filariæ in the blood of the lad Tiong-Seng (details of whose case and filarial chart are published in the Journal of the Quekett Microscopical Club, vol. vi., p. 239, No. 47, July, 1881), on July 14th and 15th, had anything to do with the subsequent febrile attack. I think not. To establish a cause and effect connexion would require many more observations and a great expenditure of time and labour. It is a hint worth following up. In the meantime I look on it as a coincidence.

I would suggest to Dr. Carter that his finding in patients in Bombay filariæ during the paroxysms of elephantoid or lymphatic fever, but not in the non-febrile intervals, is explained by his having sought for them during the day only, and not during the night. Filarial periodicity is disturbed by fever. The embryos during the febrile state, and for some time after it has subsided, are thrown into the general circulation during the day. Fever subsiding, the parasites revert to their usual nocturnal habits. Dr. Carter, working probably only during the day, therefore missed them; though had he searched the blood at night, during the non-febrile intervals, he probably would have found them.

In addition to answering Dr. Carter's letter, I would crave space for a few remarks on your report of the discussion at the Pathological Society on Dr. Mackenzie's case of filarious hæmato-chyluria.

1. Why should the disease be called "hæmato-chyluria?" The word is misleading, and evidently misled some of those who took part in the discussion. "Hæmato" implies that there was blood, and "chyluria" that there was chyle in the urine; and that therefore the pathology of the disease must include rupture both of bloodvessels and chyle-vessels. But there is no evidence whatever that filariæ attack the bloodvessels; and it would be difficult to understand how they could. The damage they do, as far as known, is entirely confined to the lymphatic system. The presence of red coagula appears to have been the only evidence for assuming that the urine contained blood. In chyluria, whether the lymphous or chylous admixture with the urine is red or white, the lymphatic system is alone affected. The varying proportion of red coagulum is easily explained without assuming rupture of bloodvessels. It is well known that lymph or chyle as it travels along the lymphatics, and especially towards the opening of the thoracic duct, acquires a red tinge and contains many discs shaped and coloured exactly like those of blood. Lymph proceeds in its development as it passes along the lymphatics and through the glands. Though the passage is arrested or retarded by filarial obstruction, development may still advance. A chyluria is sometimes milky, sometimes red; discharge from a lymph-scrotum similarly is sometimes watery, sometimes milky, sometimes red, and that in the same subject. The colour of the discharge depends entirely on the part of the lymphatic system it regurgitates from and the time it has been in the vessels. It is as absurd to suppose that chyle or lymph could escape from bloodvessels as that blood could escape from lymphatics; and it is certainly exceedingly improbable that both sets of vessels should be involved in the same way, in the same organs, and in the same individual.

2. Dr. Mackenzie remarked that filariæ were most abundant in the blood-clots. The inference from this would be that most of the filariæ came from the bloodvessels. I have shown that the clots were not blood-clots, but lymph-clots; and why the filariæ were most abundant in these is evident. The entire mass of lymph originally passed into the urine coagulated, just as blood would do in similar circumstances. The coagulum therefore included all the filariæ, and as the lymph fibrine contracted the serum was expelled, and the corpuscles and filariæ were concentrated. Hence the dark-red colour of the clots, and the large proportion of parasites they contained.

3. Dr. Carter remarked that the parent worm is probably

the cause of lymphatic obstruction. Facts, to enumerate which would occupy too much of your space, are against this supposition. I hope next year to publish evidence which shows that lymphatic obstruction is produced by ova prematurely expelled from the uterus of the parent female filaria. These ova give rise to embolism of the lymphatic glands, where, on account of their size (1-300" × 1-500") they are arrested. In ordinary circumstances neither parent nor offspring does any damage whatever. Both are perfectly adapted to live in harmony with their human host. But when the products of conception are hurried prematurely into the lymphatics before the embryo has stretched the chorional envelope which becomes its sheath, and acquired its slender eel-like vigorous form, so perfectly adapted for the passage of very fine vessels, then the filaria sanguinis hominis becomes a dangerous guest. I have twice removed ova from obstructed lymphatics, and Cobbold has found in urine ova very much like those of this parasite. What has been seen to happen once or twice happens oftener. Like other animals, the parent filaria aborts at times. Imagine an aborting worm pouring myriads of embolic ova into the lymphatics. Imagine the direct and remote effects of this according to the particular part of the lymphatic system she occupies, and all the varieties and seeming anomalies of Wücherer's helminthiasis receive an easy explanation. This, I am convinced, is the key to their pathology.

4. The explanation of the phenomenon of periodicity suggested by Dr. Carter is hardly compatible with the facts adduced by Dr. Mackenzie, and some I have been able to gather. Dr. Carter suggested that the overflow of chyle following absorption of food carried with it the embryo filariæ into the blood. But if this is the case, why are they not found in the circulation after the morning and midday meals as well as after the evening meal? and why was periodicity not disturbed when the hours of eating were changed in Dr. Mackenzie's patient? The facts connected with filarial periodicity may be best explained by one of two suppositions: (*a*) The parent worm empties her uterus of mature embryos once every twenty-four hours, parturition going on from late in the afternoon till midnight, and (as a corollary) the young filariæ living but a few hours in the blood, as Dr. Myers suggests; or (*b*) parturition is a more or less continuous process, the young being nearly constantly carried along the lymphatics and thoracic duct into the blood. In this they live for an indefinite time, circulating with it, under ordinary circumstances, during the night; but from some unknown cause, and after some unknown fashion, becoming fixed during the day. Against the assumption of intermitting quotidian reproduction are the following facts. The urine of Dr. Mackenzie's case contained filariæ both during the day and during the night. Filariæ were constantly, or nearly so, present in urine which I had caused a chylurious patient to pass every few hours for a week. Lymph from a lymph-scrotum, which had been running constantly for many consecutive days, contained embryos whether procured during the day or night; in this case the parent worm was found in the scrotum, so that the lymph into which she emitted her young could not have lain long in the vessels. The hypothesis of quotidian intermitting reproduction implies but a very short life to the embryos; but it is difficult to understand what purpose favourable to host or parasite could be served by this enormous daily mortality. Nature's object in making these creatures so prolific is evidently to provide as many chances as possible for the continuance of the species. Nor is it easy to understand why animalcules which can live for so many days outside the body of their host should die after so short a life in it.

The facts I have stated, and other evidence I do not bring forward at present, lead me to believe that the second hypothesis is the correct one—viz., that reproduction is continuous, and that the embryos are fixed or filtered out in some organ or tissue during the day. Dr. Carter correctly remarks that embryos are not always entirely absent from the blood-stream even during the day, occasionally one or two may be found then. These, I believe, have but recently escaped from the thoracic duct, and are carried once or twice the round of the circulation before they are brought thoroughly under the influence that has fixed the rest of the swarm. This hypothesis explains the prodigious numbers circulating during the night. I have counted as many as 200 in a slide 1½ in. by 1 in. This would give, on the assumption that the entire volume of this man's blood amounted to 15 lb., that the hæmatozoa were equally diffused throughout it, and that the quantity of blood examined was about half a drop, a population of upwards of 46,000,000 of embryo parasites. To give birth to this prodigious swarm every twenty-four hours is surely beyond the reproductive powers of many parents, energetic though the reproductive powers of the filariæ may be. Undoubtedly, the young parasites are exposed to many dangers, and the life of each is beset with risks, mechanical and vital; these risks keep the stock under, whilst the supply keeps pace with the loss.

5. In your comments on the discussion you say that knowledge is still wanting on the question as to the possibility of asexual reproduction in the case of this parasite. We already know that the mature forms of filaria sanguinis hominis are male and female after their kind. The female has frequently been found, and Lewis has found fragments of the male. Analogy is entirely against the supposition of asexual reproduction. The sexes, though living together, are always distinct in the case of similar blood parasites: for example filaria immitis from the heart of the dog, filaria piæ mediæ from the semilunar valves of the magpie, filaria corvi torquati from the pulmonary artery of the ringed crow of China—all of which have been carefully studied both in their mature and embryo forms. There is no reason to think that the human parasite differs in this respect from corresponding hæmatozoa in the lower animals.

6. I have repeated Dr. Mackenzie's experiment of keeping a filarious subject awake all night, allowing him to sleep during the day, and with the same result. After two or three days, during which egress and ingress of embryos were very irregular, periodicity became completely inverted.

Filarial periodicity may be only a pathological curio. I cannot but think, however, that it is in some way bound up with the many rhythmical phenomena, physiological and pathological, which have hitherto defied explanation; and from the ease with which it lends itself to experiment, its discovery may yet lead to useful results. Certainly the experiment of plugging the lymphatic glands by embolic ova performed for us by the parent worm is an interesting one, and shows well that one of the functions of these organs is to act as a filter. Were the ova permitted to enter the blood, consequences much graver than a chyluria or an elephantiasis would ensue.

I am, Sir, yours truly,

Amoy, Dec. 21st, 1881. PATRICK MANSON.

IS IODINE A DISINFECTANT?

To the Editor of THE LANCET.

SIR,—This a curious question to ask after reading Mr. Perry Marsh's letter in THE LANCET of the 4th inst. My belief is that it is not. It is an antiseptic, not a disinfectant. Like many other so-called disinfectants, such as Condy's fluid, chlorine, carbolic acid, *et hoc genus*, none of these substances are disinfectants unless used of such strength as to be destructives; moreover, the ordinary vapours of these substances not only do not destroy infection, but actually preserve it by preventing its putrefaction. They do not destroy the active properties of vaccine lymph; indeed, some years ago I read several advertisements in the medical journals, containing the following sentence, "Pure vaccine lymph preserved in carbolic acid," &c. The only real disinfectants that I am acquainted with are those which hasten putrefaction, as sulphurous acid, bisulphide of carbon, all gases that contain hydrocarbon, such as coal gas, and others of too dangerous a character to be of any practical value. These substances may be advantageously divided into three distinct classes—namely, disinfectants, that is, those substances that destroy contagion by hastening the death and putrefaction of the living germs; antiseptics, those that decompose septic or putrid animal matter by converting it into carbon, &c., and deodorisers, or those that decompose the effluvia of decaying vegetable matter. I am not aware that Dr. Richardson ever recommended iodine as a disinfectant proper, and some years ago he gave me the credit in a contemporary journal of being the first to recommend its use as an antiseptic.

A propos an article in the same number of THE LANCET, I can safely affirm, and many others, I am sure, will bear me out, that septic poison, as it occurs in the so-called cases of puerperal fever, may be and is immediately destroyed by

the accoucheur when unfortunately he has had to deal with a case of the kind, by his going into a small apartment, placing a few scales of iodine on a saucer, and holding beneath it a spirit-lamp for a few seconds, when he will be surrounded by the beautiful violet-coloured fumes of iodine, and may then go without dread or fear and attend any other female in her confinement, the septic poison having been converted into harmless carbon.

I remain, Sir, yours faithfully,

A. WYNN WILLIAMS, M.D.

Montagu-square, February 8th, 1882.

"THE RECENT FOGS."

To the Editor of THE LANCET.

SIR,—I would respectfully ask permission to express dissent from your dictum, that "smoke and fog have little in common." Allow me to state the following facts in support of my objection.

On the morning of January 21st of this year I noticed that the surface of a piece of water in my grounds was covered with a grey scum. Of this I skimmed off a small portion, which on examination with the microscope I found to consist of minute particles of soot. On the previous evening a change of wind had brought over from the direction of London a dense black fog, the source, I believe, of the film of dirt on the pond.

I observed a very similar occurrence several years ago in Upper Holloway. On one winter's day we had a heavy fall of snow which lay thick on the ground. On the same evening there came on a downright thick, peasoup fog; the next morning the pure white mantle of snow had become of a dirty brown colour from the smoke and soot deposited thereon from the fog.

I believe that many housekeepers in London and other large cities can testify to the dirt left upon curtains and window-blinds by thick fogs. Moreover, I would beg leave to state that my recollections do not correspond with yours as to the amount of fog in London in former, as compared with later, years. My memory carries me back, as a denizen of the city, beyond the "'thirties or 'forties," to the "'twenties"; but I have no remembrance of any fogs in London worse than, or even so bad as, some that we have recently experienced. Forty-four years of practice in the northern metropolitan districts would lead me to say that fogs have increased in density with the increase of buildings in the suburbs.

I remain, Sir, your obedient servant,

Enfield, Feb. 13th, 1882. W. B. KESTEVEN, M.D.

*** No one can doubt that fogs are dirty, and that, as the floating dirt of a city atmosphere is chiefly *soot*, fogs occurring in a city will generally be laden with soot; but this is a vastly different story from that which makes *smoke the cause of fogs!* As regards the observations and experience of our correspondent, which so greatly differ from our own, we can only adhere to the opinion which we have previously expressed.—ED. L.

PHTHISIS AND INFECTION.

To the Editor of THE LANCET.

SIR,—May I solicit a short space in your columns to reply to Dr. Dale's letter published in to-day's issue. Although it bristles with quite a formidable array of quotations, a great part of Dr. Dale's communication simply denies the correctness of the views adduced in my paper, and does not require further comment. One or two points, however, demand brief notice.

Referring to the production of tuberculosis by the introduction of tubercular matter into the alimentary canal, Dr. Dale says that other putrefying or septic substances introduced into the healthy body will produce pathological appearances which cannot be distinguished from those which accompany phthisis. I was not aware until to-day that the tubercular virus was either putrefying or septic. Cohnheim says that it is important that the virus should be fresh and free from taint, lest the experiment be affected by septic and other influences. I know that inoculation with cheese, brain, &c., has produced anatomical changes somewhat similar to those observed in tuberculosis. But with these anatomical appearances all resemblance ceases. Yet even admitting the truth of Dr. Dale's statement, I fail to see how it affects my argument. Moreover, Dr. Dale now acknowledges that the healthy body may be infected by the introduction of tubercular matter into the alimentary canal. He therefore admits the truth of the statement which in his previous letter he singled out of my communication to refute. No physician attempts to claim for tuberculosis the same infective power that the eruptive fevers possess; so that Dr. Dale's comparison is useless.

Dr. Dale terms Lister's germ theories "strange mistakes." They may be so; but it was upon this "false analogy," and this "unverified hypothesis," that Lister founded his grand principles of treatment which have revolutionised surgery. Dr. Dale's observations on Lister's doctrines and on contagion should be read along with his concluding remarks on phthisis in his former letter. It would be interesting to learn his views upon other current medical topics.

As I mentioned in my previous letter, I have met with other cases than those narrated which could only be explained by the theory of infection; but I adduced those two because they were supported by the opinion of gentlemen who rank deservedly high in the profession. Dr. Dale, however, has not met with similar cases; therefore, *de facto*, these authorities are wrong.

I am, Sir, yours truly,

A. M. M'ALDOWIE, M.D.

Stoke-upon-Trent, Feb. 11th, 1882.

"ISOLATION IN RINGWORM CASES NOT NECESSARY."

To the Editor of THE LANCET.

SIR,—On reading the heading of Dr. Thin's letter, and also the first paragraph of it, I was inclined to hope that at last some real improvement in the treatment of ringworm had been discovered.

That cases of ringworm of the scalp should be allowed to remain in schools without risk of the disease spreading, and that, in consequence, the children would not have education interfered with, is a matter of such vital importance, that parents and schoolmasters will be indeed grateful to Dr. Thin if his plan is successful.

As I advanced towards the end of the letter, my hopes that a solution of this difficult and complex subject had been found were somewhat shaken by the fact, that the plan suggested by Dr. Thin showed no signs of novelty. All things that are new are not true, has been said; still one hoped for something *new*, because the *old* system of covering the patches with ointments of various kinds has been tried for years in the schools of England, and with what success every medical officer knows full well.

I am, Sir, your obedient servant,

Montagu-square, Feb. 14th, 1882. MALCOLM MORRIS.

PHOSPHORUS NECROSIS.

To the Editor of THE LANCET.

SIR,—During four months in which I fulfilled the duties of house-surgeon to the Children's Hospital, Shadwell, last year, one case of necrosis of the jaw presented itself at the hospital. The patient was a boy of about twelve years, and worked at a well-known match factory. His mother stated she knew of several similar cases that had occurred among *employés* at this factory. The disease was on the left side of the lower jaw. A good deal of friable dead bone was removed by operation; and a large piece, about two inches long, afterwards separated spontaneously. The boy had decayed teeth in the left lower jaw.

Mr. Parker, under whose care the case was, refused to consider it phosphorus necrosis on account of the extreme rarity of that disease, of its very localised character, and because only amorphous phosphorus was reputed to be used at the factory in question. At any rate, the case seems to lend weight to Mr. Treves' opinion that phosphorus necrosis is commoner than is generally supposed.

I am, Sir, yours faithfully,

SIDNEY DAVIES, B.A., M.R.C.S.

Training Hospital, Tottenham, Feb. 4th, 1882.

IRELAND.

(From our own Correspondent.)

THE Standing Committee of the Royal University of Ireland have agreed to recommend to the Senate that the date of the scholarship examination be postponed to Tuesday, May 9th.

The report of the Committee of the Samaritan Hospital shows that although the institution received last year some £150 more than it expended, yet a debt of £500 still exists. The poorer patients are admitted free when there is room, but those who are able to pay are expected to defray the cost of their maintenance. This arrangement is one which works satisfactorily, and has been adopted in more than one hospital in Belfast.

The Dublin Corporation have adopted a report of the Public Health Committee, recommending an application for a loan of £500,000, to carry out the provisions of the Labouring Classes Dwellings Act, £20,000 to be in the first instance applied for.

The Local Government Board have authorised the Belfast Guardians again to prosecute a Mr. Strain, of that town, for refusing to have his child vaccinated. He has already been fined three or four times; but on the last occasion when summoned for the offence the magistrate, although he had a few months before inflicted a fine, dismissed the prosecution with costs against the Guardians. At the present time small-pox prevails to a considerable extent in Belfast, there being for the week ending the 4th inst. no less than 140 patients suffering from this disease in the Union Hospital.

There has been a severe epidemic of measles in Dublin during the past few months, which assumed serious proportions about the middle of December, and has since spread widely. From the 24th December to the 21st January last 161 deaths were recorded from this disease.

Fever prevails to some extent at Queenstown; but a considerable number of the Town Commissioners appear to object to the expenses incurred for disinfecting the clothes of the fever patients. Last week a discussion took place as to the payment of a sum of thirty-five shillings for this purpose, when a resolution to pay the money was carried by only one vote. The 137th section of the Public Health Act shows that this duty devolves exclusively on the sanitary authority—the Town Commissioners in this instance; but it has required a considerable amount of pressure on the part of the Local Government Board to induce them to perform a plain and distinct duty.

Richard Barrett, M.D., of Carrigafoocka House, Macroom, has been placed on the Commission of the Peace for the County Cork.

During last year 295 patients were admitted into the Belfast Hospital for Sick Children, while 6721 were attended to at the extern department of the hospital. A scheme for the introduction of lady probationers has for some time exercised the attention of the committee, and after consideration it has been decided that the opportunity should be given to those desirous of learning how to become efficient nurses to take advantage of the benefits of the hospital.

PARIS.

(From our own Correspondent.)

M. MILNE-EDWARDS, the President of the Commission appointed by the Academy of Sciences to report upon M. Dumontpallier's experiments on hypnotism, read a short note on the subject, which will probably bring the inquiry to an abrupt termination. He stated that Professor Harting, of Utrecht, had communicated to him the results of similar experiments made on rabbits, fowls, guinea-pigs, pigeons, and frogs. The six fowls submitted to hypnotism on several different occasions died of paralysis. M. Milne-Edwards announced that he would carry out analogous experiments at the Jardin des Plantes, but that they must be considered as too dangerous to be performed upon human beings without considerable circumspection. M. Vulpian had already marked his appreciation of this kind of inquiry by withdrawing from the commission. Whether there is really any immediate risk to an hysterical girl from the treatment she receives in a Paris hospital may be open to doubt, but there can be no question that in the long run it is extremely injurious.

It is a common thing to see a robust, rosy young woman admitted into the wards with a diagnosis of "accidents hystériques." This is in itself, in a town like Paris, where hospital accommodation is so insufficient, a foul abuse. A series of investigations into the state of every organ and function is then made, with the necessary result of perverting them from health, and after a time the patient becomes profoundly anæmic, developing into a fine specimen of "hysteria major." This condition of things may continue for some months or years, but eventually the patient will be discharged, broken down in health by her treatment in hospital, and entirely unfit to return to her former occupation.

A pharmaceutical chemist has recently been condemned to a fine of six hundred francs, under the following circumstances:—A proprietary medicine, manufactured and sold by him under the name of "anti-obesitas," purported to be prepared according to a recipe known in Egypt for centuries, and to be composed of aromatic herbs and flowers growing along the banks of the Nile. Analysis showed that the chief ingredient was iodide of potassium.

The death is announced of M. Cossy, Chef de Clinique of the Hôpital des Enfants Assistés, who succumbed to diphtheria, contracted in the wards. From Nantes comes the news of the death of a student from small-pox, taken in the barrack-hospital to which he was attached.

Obituary.

SURGEON-MAJOR MOFFITT, A.M.D.

THE Medical Department of the Army has sustained a severe loss in the death of the above named officer, who succumbed to a mortal disease in Southampton on the 8th inst. Dr. Moffitt entered the service in the year 1858. In the following year he served with the 67th Regiment in China, where he made the acquaintance of Colonel (then Major) Gordon, the famous commander of the ever-victorious army, whose brother-in-law he afterwards became. To this army he was appointed principal medical officer, and quickly displayed all the qualifications required for such a position. "It is impossible," says the historian of Gordon's operations, "to over-estimate the good done by Dr. Moffitt, not only to the force in which he served with so much distinction, but to the reputation of his profession and country." Colonel Gordon has in every possible way testified to the value of his services, and has always said that the confidence inspired by Moffitt's surgical skill was so great as to nerve the minds of the soldiers to engage without fear in the many hazardous enterprises of that war. Nor was this all. Dr. Moffitt on several occasions, when combatant officers, strictly so-called, were few, led the troops into action. Dr. Moffitt's war services are thus given in Hart's Army List: "Served through the campaign of 1860 in the north of China (medal), also in the operations around Shanghai against the Taepings in 1862, and was present at the capture of the cities Nayscien, Kading, Najon, and Cholin; entered the service of the Emperor of China with Major Gordon, Royal Engineers, and served with the disciplined Chinese force as principal medical officer until its dissolution, being present at thirty-three engagements against the rebels (presented by the Emperor of China with a general service medal of the first class, and a second special gold medal)." On his return home, Surgeon-Major Moffitt served for five years on the staff of the Royal Victoria Hospital, Netley, acting as instructor of the Army Hospital Corps, for whose use he prepared a valuable manual, which is still the text-book for their instruction. This work was published by the War Office, but, for some reason never explained, without the author's name—an omission keenly felt by him and resented by his friends. His tour of service at Netley completed, Surgeon-Major Moffitt went to India, and served the usual five years' tour of duty in the Bombay Presidency. There his high professional qualities soon became known, and there, as elsewhere, he secured the love and esteem of all with whom he had relations for his devotion and zeal in the discharge of severe and responsible duties. He returned

to his native land shattered in health and with the seeds of the disease which at last proved fatal. In the course of last year he went to Homburg in search of health, but did not find it. There his disease, aneurism of the thoracic aorta, developed with rapidity. He was brought home with difficulty, and from that time until relieved by the kindly hand of death his sufferings were extreme, reaching the utmost limit of human endurance, but borne with a dignity and fortitude that will be remembered with admiration to their lives' end by those who were privileged to witness it. It may be permissible to add that "he died the death of the righteous," with a triumphant expression of hope on his lips. The fittest memorial to cut on his tomb may be thus briefly written, "Patient in tribulation."

EDWARD B. THRING,

DEPUTY INSPECTOR-GENERAL OF HOSPITALS.

WE have to record the death of Edward Brounker Thring, of the Indian Medical Service, at Dawlish, on the 30th of January. He served in India for twenty-eight years, retiring in 1869 while holding the office of Deputy Inspector-General of Hospitals. Mr. Thring belonged to the old Wiltshire family of that name, and was born at Warminster in 1819; was educated at Bruton grammar school, travelling afterwards with a tutor on the Continent for three years; he then entered the Bristol Hospital as pupil to the well-known Mr. Richard Smith, thence he went to St. Bartholomew's, and, obtaining an appointment in the Hon. East India Company's Service, went to India in 1841, served with various regiments in Bengal and the upper provinces till the great demand for medical officers in Scinde caused him to be sent there. The effect of climate and hard work brought on Scinde fever, and he was ordered to England. In 1850 he returned to India, obtained the appointment of Civil Surgeon at Midnapore, and continued to hold civil appointments till his promotion in 1855. He was then appointed to the 32nd Regiment at Barrackpore, and marched with them to Saugor in November, 1856. In the following May the mutiny broke out, and all the Europeans in Saugor were ordered by General Sage into the fort. Anxiety and fatigue, with the unhealthy situation, told severely on all, but on none more than on the medical men, who shared the guard with the other officers, and had their sick and wounded in addition to attend to. Sir Hugh Rose arrived at Saugor on Christmas-day, 1857, and Mr. Thring with a part of the faithful 32nd Regiment was sent into the disturbed districts of Bundelcund. In the autumn of 1859 an escort was obtained from Lord Canning, and the ladies and invalids from Saugor reached Allahabad in safety, Mr. Thring and his family amongst the number. After a few months in England he considered his health sufficiently improved to return to India, and there served as Deputy Inspector-General of Hospitals until his retirement in 1869.

MEDICAL NOTES IN PARLIAMENT.

Anti-Vaccination.

IN the House of Commons on Thursday, the 9th inst., a petition was presented from the General Council of the University of St. Andrews in favour of university reform. The twenty-third report was presented of the Board of Superintendence of Dublin Hospitals. A copy was presented of an Order in Council approving certain regulations under the Pharmacy Act (Ireland). A return under the Lunacy Regulation Act, 1862, was laid upon the table. A Bill to amend the law relating to University Education in Ireland was read a first time. A division was taken on Mr. P. A. Taylor's motion for leave to bring in a Bill to repeal the compulsory clauses of the Vaccination Acts, which was humorously opposed by Mr. Warton as "a Bill for spreading small-pox." In the result leave was given by 107 votes to 58, and the Bill was read a first time on Friday.

Vivisection.

A Bill to amend the Constitution of the Universities Committee of the Privy Council was brought in by Mr. Bryce, and read a first time on Friday.—Mr. Reid's Vivisection Abolition Bill was read a first time, and put down for second reading on March 29th. Mr. A. J. Balfour has given notice that on the order for the second reading he will move the following amendment:—"That while due provision should be made for preventing the infliction of unnecessary pain on animals, it is inexpedient so to limit scientific investigation as to hinder discoveries which must result in a great diminution of human suffering."

Bills for the amendment of the law relating to the Notification of Diseases in England and Ireland were read a first time; as also was Mr. O'Sullivan's Bill for the Improvement of Spirits in Bond.

On Monday, Mr. Firth gave notice that he would move for a return of the Reports made by Dr. W. H. Power and Dr. Thorne to the Local Government Board as to Small-pox Hospitals, and their effect on surrounding populations.

Omagh Gaol.

On Wednesday, in answer to questions put by Mr. R. Power and Mr. Gray, Mr. Forster said he regretted to say it was true that Mr. Disney, the governor of the gaol at Omagh, died in that prison from typhoid fever. The sewer was defective, and was being remedied. He had ascertained that the part of the prison in which the suspects were confined was perfectly healthy. With regard to the other prisons, the architect of the prisons Board, Captain Palmer, reported that the sanitary arrangements were satisfactory. In Kilmainham the sanitary arrangements were also good, and there was no intention to make any alterations.

Christ's Hospital.

In answer to Mr. Serjeant Simon, who asked for particulars as to the sanitary arrangements of the preliminary school at Hertford in connexion with Christ's Hospital, Mr. Dodson said that during the last ten years there had been six epidemics of measles and eleven of scarlet fever. There were 403 cases of the former, of which five died, and ninety-five of the latter, including four deaths. The water-supply was good, and there were no still cesspools in the school or neighbourhood. The drainage was in the hands of the corporation, and the sewage was conveyed a mile from the town. The soil was gravel on chalk; and, judging from the low death-rate of Hertford, the locality was not unhealthy.

Medical News.

UNIVERSITY OF CAMBRIDGE. — At a congregation held on the 9th inst. the following degrees were conferred:—

M.D.—William Ewart, Caius.

M.B.—Duncan Burgess, George Maurice Hoblyn Colman, and Arthur Wyndham Standert, Corpus Christi; Alexander Hill, Downing.

APOTHECARIES' HALL. — The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on Feb. 9th:—

Crone, John Smyth, Evershot-road, Tollington-park.
Dunn, Louis Albert, Cavendish-place, Brighton.
Erulkar, Solomon Abraham, The Avenue, Acre-lane, Brixton.
Phillips, Henry Astley, Leicester-square.

The following gentlemen also on the same day passed the Primary Professional Examination:—

Thomas Cardwell, John Ascroft Littlewood, and John George Milnes, Guy's Hospital; Stanley Stenton Hoyland, St. Bartholomew's Hospital; Walter Spencer, Charing-cross Hospital.

The following candidate passed in Elementary Chemistry on the 27th ult.:—

Francis William Jollye.

THE Senatus Academicus of St. Andrews University has conferred the honorary degree of LL.D. on Dr. J. Hutton Balfour, of Edinburgh.

AN addition of £50 has been made to the salary of Dr. Cooper, medical superintendent of the infirmary of St. George's-in-the-East.

DURING the present week a canvass of the city of Bristol and neighbourhood has been carried on for the benefit of the funds of the infirmary.

THE CHILDREN'S HOSPITAL, PENDLEBURY.—The number of patients treated in the wards of this institution during 1881, according to the report read at the fifty-third annual meeting held a few days ago, was 5773; of whom 972 were made home patients. The deaths were 170. The financial condition of the hospital was described as more encouraging than last year.

THE Duke of Albany has consented to preside at the festival of the National Hospital for the Paralysed and Epileptic, to be held at the Freemasons' Tavern on the 14th of March next.

THE Saturday and Sunday Hospital Fund in New York for the present year had amounted, up to Jan. 23rd, to 38,884 dollars. It is expected that 50,000 dollars will be raised before the books are closed.

VACCINATION GRANT. — George Lowe, M.B., Middleton-in-Teesdale, Durham, has been awarded a Government grant for proficiency in vaccination in his district.

ON the 10th inst. a fire broke out on the premises of the Bicton Lunatic Asylum, near Shrewsbury. The conflagration was, however, fortunately confined to the semi-detached building in which it originated.

ON the 13th inst. a farewell dinner was given at Limmer's Hotel by a number of gentlemen engaged in the city of London, in connexion with Australian commerce, to Dr. Arthur M. Oram, on the occasion of his departure for Australia to practise his profession.

AT a meeting of the Greenwich Board of Guardians last week, it was proposed, and carried by a large majority, spite of an amendment, moved by a medical member of the Board, that a £15 gratuity be awarded to each of the Deptford medical officers, and one of £10 each to the Greenwich medical officers.

SANITARY INSTITUTE OF GREAT BRITAIN.—At the ordinary meeting held at 9, Conduit-street, on Feb. 15th, Professor F. S. B. F. De Chaumont, M.D., F.R.S., in the chair, a paper was read by Henry C. Burdett, F.S.S., on the Administration and Hygiene of British Hospitals. A short discussion followed, in which Mr. E. C. Robins, Dr. Braxton Hicks of Guy's Hospital, Mr. C. Macnamara of Westminster Hospital, and Mr. Pearson Hill took part.

THE report of the committee read at the annual general court of governors of the Royal Hospital for Women and Children, held last week, recounted much good work done by the institution during the past year. Amongst other services rendered by the charity were the admission of upwards of thirty women and children after the inundations caused by the storm of Jan. 18th, 1881, and the relief of seventy-five families, with the aid of special contributions from the public.

AT the quarterly meeting of the Medical Temperance Association, held in the rooms of the Medical Society of London on the 14th inst., Dr. Norman Kerr exhibited and described eight varieties of unintoxicating wine prescribed by him medicinally, and recommended as social beverages. These were all genuine wines, the pure juice of their respective grapes. Among the best were Riessling (German), Madeira (Madeira), Lachrymæ Christi (Italian), Bordeaux (French), Muscat (French), and Alto Douro (Oporto). The importer, Mr. F. Wright (Kensington), also had produced an unfermented port with bark, which was an elegant, agreeable, and useful tonic wine.

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning, at the latest.*

ANDERSON, WILLIAM S., M.B., C.M.Glas., M.R.C.S., has been appointed Medical Officer to the Chapel-en-le-Firth District of the Chapel-en-le-Firth Union, vice Bennett, resigned.

ASH, T. LINNINGTON, L.R.C.P.Ed., M.R.C.S., L.S.A.Lond., has been reappointed Medical Officer of Health to the Okehampton Rural Sanitary District.

ASHBY, ALFRED, M.B.Lond., F.R.C.S.Eng., has been appointed Public Analyst for the Borough of Newark.

BARTLETT, JACOB HARRY, L.R.C.P.Ed., L.F.P.S.Glas., has been appointed Medical Officer to the Leatherhead and Fetcham District of the Epsom Union.

BARTON, W. E., M.R.C.S., L.R.C.P.Lond., L.S.A.Lond., has been appointed Medical Officer and Public Vaccinator to the Burwash District of the Ticehurst Union.

BLAXLAND, HERBERT, L.R.C.P.Lond., M.R.C.S., has been appointed Medical Superintendent of the Hospital for the Insane at Callan park, New South Wales, vice Dr. Scholes, resigned.

BROADBENT, JOHN, M.R.C.S., L.S.A.Lond., has been appointed Honorary Surgeon to the Hulme Dispensary.

BUTLER-SMYTHE, ALBERT C., M.R.C.S., has been appointed Surgeon to the Farringdon General Dispensary and Lying-in Charity, vice Blake, resigned.

DAVIES, SIDNEY, M.R.C.S., has been appointed House-Surgeon to the Evangelical Protestant Deaconesses' Institution Training Hospital, Tottenham.

EMERYS-JONES, A., M.D.Edin., M.R.C.S., has been appointed Honorary Surgeon to the Manchester Royal Eye Hospital.

FAIRCLOUGH, J. J. KENT, M.D., M.Ch.Q.U.I., L.K.Q.C.P.I., M.R.C.S., has been appointed Honorary Surgeon to the Hulme Dispensary.

FIELD, JAMES W., M.R.C.S., L.R.C.P.Ed., has been appointed House-Surgeon to the London Lock Hospital, Dean-street, Soho, W., vice J. N. Cook, M.R.C.S., resigned.

HEISCH, Mr. CHARLES, has been appointed Public Analyst for the Borough of Hertford, vice Tidy, resigned.

JONES, THEOBALD E., L.R.C.P.Ed., L.F.P.S.Glas., has been appointed Medical Officer to the Workhouse of the Chapel-en-le-Firth Union, vice Bennett, resigned.

LUBBOCK, M., M.D., M.R.C.P.Lond., has been appointed Assistant-Physician to the Charing-cross Hospital, vice Houghton, resigned.

NETTLE, WILLIAM, M.R.C.S., L.S.A.Lond., has been appointed Medical Officer to the First District of the Liskeard Union.

POLLARD, WILLIAM ROBERT, L.R.C.P.Ed., L.R.C.S.I., has been appointed Medical Officer to the Mellor District of the Blackburn Union.

POPE, CHARLES, L.R.C.S.Ed., L.R.C.P.Ed., has been appointed Medical Officer to the South Shields Workhouse, vice Dr. Denham, deceased.

PROSSER, T. GILBERT, M.R.C.S., L.S.A.Lond., has been appointed Medical Officer to the Monmouth District of the Monmouth Union.

REID, WILLIAM, M.B., C.M.Aber., has been appointed Assistant-Superintendent of the Royal Lunatic Asylum, Aberdeen.

RHODES, WILLIAM, L.R.C.P.Ed., M.R.C.S., has been appointed Medical Officer to the Third District and the Workhouse of the Bridgnorth Union, vice Colles, resigned.

ROY, WILLIAM, M.D.Ed., has been appointed Physician to the North Cambridgeshire Hospital, vice Nicholls, deceased.

SCOTT, R. J. H., M.R.C.S., has been appointed Honorary Surgeon to the Eastern Dispensary, Bath, vice H. C. Hopkins, M.R.C.S., resigned.

SHEARS, C. H. B., L.R.C.P.Lond., M.R.C.S., has been appointed House-Surgeon to the Liverpool Eye and Ear Infirmary, vice C. Atkin, L.R.C.P.Lond., M.R.C.S., resigned.

WILLIAMS, W. LLOYD O., M.B., C.M.Ed., has been appointed Medical Officer and Public Vaccinator for the Llanrug District of the Carnarvon Union.

Births, Marriages, and Deaths.

BIRTHS.

HOWARD.—On the 26th ult., at Montreal, Canada, the wife of R. Palmer Howard, M.D., of a daughter.

MACNAB.—On the 9th inst., at Bury St. Edmunds, the wife of Robert Macnab, M.D., F.R.C.S.Ed., of a son.

MAISEY.—On the 8th inst., at Charlbury, Oxon, the wife of Frederick Thomas Maisey, M.R.C.S., L.S.A.Lond., of a daughter.

PHILPOTS.—On the 8th inst., at Moorcroft, Parkstone, Dorset, the wife of John R. Philpots, L.R.C.P.Ed., L.R.C.S.Ed., of a daughter.

THOMPSON.—On the 8th inst., at Wellington-square, Oxford, the wife of Harold Thompson, M.R.C.S. (prematurely), of twin girls, who only survived their birth a few hours.

WALKER.—On the 6th inst., at Hotham House, High-street, Putney, the wife of Alexander Walker, M.D., of a son.

WEATHERLY.—On the 9th inst., at Portishead, Somerset, the wife of Lionel Alexander Weatherly, M.D., of a daughter.

MARRIAGES.

BEEVOR—LEADAM.—On the 7th inst., at the Parish Church, St. Marylebone, by the Rector, the Rev. C. J. Phipps, Esq., Charles Edward Beevor, M.D.Lond., M.R.C.P., eldest son of the late Charles Beevor, F.R.C.S., of 129, Harley-street, to Blanche Adine, third daughter of the late Thomas Robinson Leadam, M.D., of Stratfield House, Mortimer, Berks.

MURPHY—LOS.—On the 9th inst., at the British Embassy at the Hague, James Murphy, M.D., of Holly House, Sunderland, to Adelaide Harriett Lucretia (Leda), eldest daughter of Peter Roland Los, Esq., of the Hague, formerly Consul for the Netherlands at Sunderland.

PRONGER—PUXON.—On the 7th inst., at the Parish Church, Croydon, Charles Ernest Pronger, L.R.C.P., M.R.C.S., of Barnstaple, North Devon, to Edith Frances, daughter of E. W. Paxon, of Wintons, Croydon.

WILSON—GRAHAM.—On the 31st ult., at St. John's, Princes-street, Edinburgh, Francis Wilson, L.R.C.P. &c., of Heighington, to Miss A. Graham, of Alpine Villa, Darlington.

DEATHS.

COWAN.—On the 6th inst., suddenly, Alexander Oswald Cowan, M.D., of Church-hill, Edinburgh, aged 47.

DUPLEX.—On the 7th inst., at Torrington-square, W.C., George Duplex, M.D., aged 78.

GADSBY.—On the 9th inst., at Mansfield, of diphtheria, contracted in performing tracheotomy on a diphtheritic patient, John Topham Gadsby, M.D.Lond., aged 28.

MONTFORD.—On the 8th inst., at 2, Stanley Villas, Union Mills, Isle of Man, Henry Montford, M.D., late of Douglas, Isle of Man, aged 66.

PALMER.—On the 6th inst., at Kenilworth House, Southsea, the residence of his uncle, W. A. Way, solicitor, Edward Talbot Palmer, M.R.C.S., L.S.A.Lond., aged 22.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

Medical Diary for the ensuing Week.

Monday, Feb. 20.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS. — Operations, 10½ A.M. each day, and at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
ST. MARK'S HOSPITAL.—Operations, 2 P.M.; on Tuesday, 9 A.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor W. K. Parker, "On the Morphology of the Mammalian Skull."
MEDICAL SOCIETY OF LONDON.—Dr. J. Braxton Hicks will narrate Two Cases of Abdominal Disease of clinical interest.—Dr. Day will give the details of a Case of Inflammation of the Appendix Vermiformis followed by Fatal Peritonitis.—Mr. Spencer Watson will relate the Notes of a Case of large Gall-stone impacted in the Bowel and simulating Abdominal Tumour.—Mr. Parrott will exhibit a Gall-stone of unusual size.—The President will also exhibit Gall-stones.

Tuesday, Feb. 21.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 3 P.M.
ROYAL INSTITUTION.—3 P.M. Professor John G. M'Kendrick, "On the Mechanism of the Senses."
ANTHROPOLOGICAL INSTITUTE OF GREAT BRITAIN AND IRELAND.—8 P.M. Mr. J. E. Price, "Note on Aggri Beads."—Mr. A. Macfarlane, "On Analysis of Relationships of Consanguinity and Affinity."—Mr. A. W. Howitt and the Rev. Lorimer Fison, "On from Mother-right to Father-right."
PATHOLOGICAL SOCIETY OF LONDON.—8.30 P.M. The following specimens will be shown:—Cardiac Hypertrophy; Acute Fatty Degeneration of Heart; Specimens of Gout; Osteoma of Tibia; Changes in Medulla Oblongata causing Sudden Death; Sarcoma of Bladder; Arthritis of Wrist-joint; Femoral Arteries Tied for Aneurism; Congenital Hypertrophy of Toes; Chronic Hydrocephalus; Anomalous Nerve Disorder in Infancy (for Dr. Elder, of Nottingham); Multiple Osteochondromata (living specimens).

Wednesday, Feb. 22.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.
MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
ST. MARY'S HOSPITAL.—Operations, 1½ P.M.
LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.
GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.—Skin Department.—1.45 P.M., and on Saturday at 9.15 A.M.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor W. K. Parker, "On the Morphology of the Mammalian Skull."
HUNTERIAN SOCIETY.—8 P.M. Address by the President, Dr. Hughlings Jackson.—Dr. Stephen Mackenzie, "On some Cases of Acute Poliomyelitis."

Thursday, Feb. 23.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.
CHARING-CROSS HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.
HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M.
NORTH-WEST LONDON HOSPITAL.—Operations, 2½ P.M.
ROYAL INSTITUTION.—3 P.M. Dr. P. L. Sclater, "On Geographical Distribution of Animals."
ABERNETHIAN SOCIETY (St. Bartholomew's Hospital).—Mr. C. E. Paget, "On Tobacco."

Friday, Feb. 24.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.
ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.
KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor W. K. Parker, "On the Morphology of the Mammalian Skull."
QUEKETT MICROSCOPICAL CLUB.—8 P.M. Mr. T. Charters White, "On the Histological Development of the Larva of Corethra Plumicornis."
ROYAL INSTITUTION.—8 P.M. Professor Odling, "On Sir B. C. Brodie's Researches on Chemical Allotropy."
CLINICAL SOCIETY OF LONDON.—Report of the Committee on Dr. Finlay's Case of Aortic Aneurism.—Mr. R. J. Godlee, "On a Case in which a Piece of Grass Swallowed by a Child made its exit in an Intercostal Space."—Dr. Geo. Johnson, "On a Case of Sudden Perforative Pneumothorax, with rapid and complete recovery."—Mr. Spencer Watson, "On a Sequel to a Case of Eyeball Tension, reported in the Clin. Soc. Trans., vol. xiv."—Mr. G. Lawson, "On a Case of Chimney Sweep's Cancer of the Axilla treated by Excision of the Growth, Ligature of Axillary Artery and Amputation of the Arm at Shoulder-joint."—Dr. T. H. Green will show a Case of Subcutaneous Fibroid Nodules in Rheumatism.—Mr. B. Squire will show a Case of Lupus of the Forehead treated by Erasion and Linear Scarification.

Saturday, Feb. 25.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.
ROYAL INSTITUTION.—3 P.M. Mr. W. Watkiss Lloyd, "On the Iliad and Odyssey."

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Stewart's Instruments.)

THE LANCET OFFICE, Feb. 16th, 1882.

Date.	Barometer reduced to Sea Level, and 32° F.	Direction of Wind.	Dry Bulb	Wet Bulb	Solar Radia in Vacuo	Max. Temp Shade	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
Feb. 10	30·25	S.W.	36	35	..	46	36	..	Overcast
,, 11	29·97	S.W.	41	40	..	53	41	..	Foggy
,, 12	29·88	W.	48	47	..	55	48	..	Fine
,, 13	30·06	S.W.	48	45	..	54	48	..	Cloudy
,, 14	30·16	W.	52	50	..	58	52	..	Cloudy
,, 15	29·77	N.	45	45	..	47	45	..	Raining
,, 16	30·45	N.W.	37	35	..	45	37	..	Fine

Notes, Short Comments, and Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

Letters, whether intended for publication or private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe, or recommend practitioners.

Local papers containing reports or news-paragraphs should be marked.

Lectures, original articles, and reports should be written on one side only of the paper.

All communications relating to the editorial business of the journal must be addressed "To the Editor."

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

THE ALFRED HOSPITAL, MELBOURNE.

DR. SKINNER, resident surgeon to the Alfred Hospital, Melbourne, in a letter to the committee, gives an account of the sanitary condition of this institution, which is simply deplorable. The waste products of the hospital, he says, are removed by three different routes, viz.:—(1) Closet-pans, which are seldom removed and cleaned, and the contents of which are deposited on the ground, and insufficiently covered with earth, at a distance of but twenty or thirty yards from the surgical ward. (2) Underground tanks, of which there are three, holding each 400 gallons, and which are employed to receive the liquid excreta from the wards. The contents of these tanks are pumped out at uncertain intervals, and thrown anywhere over the ground. Moreover, there appear to be no traps to the pipes leading to these tanks, so that the effluvia from them pass freely into the wards! (3) Underground drains, with but a slight gradient, no traps, and no provision for flushing or ventilation. Into these drains pass the washings of the dead-house and post-mortem rooms, and of the urinals, together with slops of all descriptions. The method of using the sewage for irrigation purposes would seem to have been devised with an almost total disregard of the dangers and offensiveness of foul gases. The main drain has been cut in three places, and led through three barrels sunk in the ground with their tops flush with the surface. The lower opening of the drain is plugged, and the sewage is made to rise about a foot and a half till it overflows the cask, and is led by a network of channels all over the garden in which convalescents are supposed to obtain the benefit of fresh air. The injurious effects of these noxious arrangements on the inmates of the hospital, both patients and officials, must necessarily be great and manifold, and sufficient, one would think, to rouse the authorities to instant action. But it appears that the resident medical officer is subordinate to a lay superintendent, who may well be understood to have an insufficient appreciation of the necessity of the utmost cleanliness in houses intended for the cure of the sick as well as of the completeness of all the arrangements designed to contribute to their comfort and recovery.

Subscriber to THE LANCET (Freiburg), *Chirurgeon*, and *F.R.C.* have not enclosed their cards.

Adcat might apply to Messrs. Moore and Co., St. Mary-axe, E.C.

Mr. E. F. Grün.—We are not aware that the condition has been noted in purpura. The case deserves publication.

PROFESSIONAL FEES IN CANADA.

THE Board of Governors of the College of Physicians and Surgeons of Quebec have adopted a new tariff of professional fees. A few items of this scale may be interesting to practitioners in this country. Thus visits from 8 A.M. to 9 P.M., not exceeding half a mile, are to be remunerated by 2 dols.; from 9 P.M. to 8 A.M., for the same distance, 4 dols.; each additional mile in the daytime, ½ dol.; at night, 1 dol.; consultation, with special examination, or with a practitioner, 5 dols.; by letter, 10 dols.; post-mortems, 10 dols.; ordinary midwifery (subsequent attendance extra), 15 dols.; setting fracture of thigh, 25 dols.; do. leg or arm, 20 dols.; amputation of thigh, 100 dols.; do. leg or arm, 50 dols.; operation for strangulated hernia, 100 dols.; lithotomy or lithotrity, 200 dols.; ovariotomy, 500 dols. The above charges for surgical aid are for the operations only.

"SULPHIDE OF CALCIUM."

To the Editor of THE LANCET.

SIR,—In reply to "Healing," I would strongly advise him to relinquish the idea of giving calcium sulphide in solution or suspension. In pill form, too, it rapidly spoils. It is impossible to disguise its filthy taste and odour, especially for little patients; but a most elegant and efficacious form to administer it in is the little granules prepared by Chanteaud, of Paris, of whom Messrs. Burgoyne, Burbidges, and Co., 16, Coleman-street, are the agents. Each granule contains a centigramme (about one-sixth of a grain) of the sulphide, is quite tasteless, and taken with ease by children. That they contain the sulphide can be quickly proved by anyone having the temerity to suck one. A sceptical medical friend one day demonstrated this most conclusively, rendering his mouth and the room in which we were for some time intolerable by reason of the stench of the sulphuretted hydrogen. I would recommend its administration in the manner set forth in THE LANCET of Dec. 10th last on "Advanced Pharmacy"—viz., by frequently repeated doses until the system is saturated, and the odour is given off by the skin and lungs, and then at longer intervals.

"Healing" does not mention in what cases he is prescribing the sulphide, but it is a most potent remedy in other affections besides boils and skin troubles, and is destined to play a most important *rôle* in the future as the great germicidal remedy. It is thus invaluable in croup and diphtheria. Dr. A. Fontaine, of Bar-sur-Seine, has treated over 400 of these cases, and finds the mortality reduced from 16 to about 6 per cent. The false membranes are quickly detached and expelled, leaving a healthier mucous memorane. This result is no doubt due to the germicidal power of the sulphide on the minute organisms which are the cause of these diseases; it is quickly and freely eliminated by the mucous membrane as well as by the skin, and thus produces its toxic effect on the part which the disease chooses as its site. Hence the advantage of giving the remedy in very frequent doses in these affections, which run so rapid and fatal a course (say one-sixth of a grain every half-hour or hour till saturation, then every third hour).

I am, Sir, your obedient servant,

Spondon, Derby, Feb. 6th, 1882. B. WALKER.

To the Editor of THE LANCET.

SIR,—In reply to the inquiry of "Healing" as to the solubility of the above drug, he will find that glycerine is the best vehicle in which to administer it to children. Five grains of the sulphide dissolve fairly well in four ounces of glycerine, or a fraction (1-32nd) over 1-8th of a grain to the drachm. A few drops of tincture of lavender added to this will hide any white turbidity occasionally seen (usually entirely due to insoluble caustic lime), and make it more palatable. A cold watery solution (one part in fifty) may be made perfectly clear by simple rapid filtration, and the filter will rarely contain more than a trace (usually none) of the sulphide, but only the insoluble lime, though this may involve inaccuracy as to the dose, which the first-named method does not.

I am, Sir, yours truly,

Leeds, Feb. 14th, 1882. P. J. HUDSON, M.B., L.R.C.P. Lond.

To the Editor of THE LANCET.

SIR,—In answer to your correspondent, "Healing," Ringer's formula is 'mix a grain of sulphide of calcium with half a pint of water, and give to a child a teaspoonful hourly." Richardson, of Leicester, makes up into soluble coated pills any dose of the sulphide, from one-tenth of a grain to a grain. I am, Sir, yours truly,

Feb. 6th, 1882. M.D.

THE SALICYLATES IN THE TREATMENT OF RHEUMATISM.

To the Editor of THE LANCET.

SIR,—In the many papers and discussions as to the action of the salicylates I have not seen any reference to the remarkable cholagogic power that Dr. Rutherford relates of the salicylate of soda. The influence of this drug in relieving rheumatic pain seems akin to the influence of potash in relieving neuralgic pain in persons who habitually excrete much lithic acid. I have often found drachm doses of potash bicarbonate act promptly when guarana and nervine sedatives fail. The depurating power of liver and kidneys seems hardly to have received sufficient attention in the late discussions on the treatment of rheumatism.

I am, Sir, yours, &c.,

Queen's-crescent, Haverstock-hill, N.W., H. FLY SMITH.
Feb. 8th, 1882.

BEER IN WORKHOUSES.

UNQUESTIONABLY the aged inmates in workhouses require beer. It is an act of fatuous cruelty to try to enforce total abstinence on the poor in their declining years and in the days of their humiliation, such humiliation as results from the sense of dependence. Dr. Dunlop, the medical superintendent of the St. Pancras Workhouse, was amply justified in the opinion he expressed at a recent inquest. "The doctor said that he was perfectly satisfied that beer was a necessary adjunct to the dietary of old paupers, and he was very sorry to know that it had been discontinued." This is our own opinion, the result of a judgment matured and frequently expressed in these columns. Medical officers of workhouses are not justified in experimenting in teetotalism on the aged poor.

CONCURRENT MEASLES AND SCARLET FEVER.

To the Editor of THE LANCET.

SIR,—Two sisters were seized with a sharp attack of scarlet fever on Oct 14th, 1881. This fever was present in the adjoining houses at the same time. V——, one of the sisters, developed well-marked measles on Oct. 24th, after the scarlet fever rash and sore-throat had subsided. The school to which V—— goes, and of which I am medical attendant, had to be broken up at this time on account of an outbreak of measles, so that in V——'s case therefore the poisons of scarlet fever and measles were active at one and the same time. That such can be the case is now granted, though it is always noteworthy when it occurs. V—— and her sister were kept in their room until desquamation had ceased, about seven weeks after the onset of the fever. They went back to school and mingled with their fellows after having been very carefully disinfected as to persons, clothing, &c., and no infection or contagion followed in their wake, though they have a brother who was susceptible to both these illnesses. On Jan. 25th, 1882, that is, nearly fifteen weeks after the commencement of the scarlet fever and fourteen weeks after that of the measles, V—— is present at a children's party in the house of a West-end physician. Next day six of these children were seized with measles, and almost equally quickly a seventh has, I understand, developed scarlet fever. In a letter to the mother of my patient the physician, who had known V—— to have had scarlet fever and measles, and without employing the method of exclusion, charges the outbreak of both measles and scarlet fever to the presence at the party of V——. As to my mind this opinion seems wild, I shall be glad if you or any of my *confrères* will, either from personal experience or from medical literature, furnish a case to support the physician's view.—I am, Sir, yours, &c.,

Feb. 2nd, 1882. A FAMILY DOCTOR.

Mr. W. Powell.—Complaints of the kind are constantly reaching us. See THE LANCET of last week.

Vesper.—Next week.

Dr. Miller.—The subject will receive notice next week.

REPEATED DISLOCATION OF THE PATELLA.

To the Editor of THE LANCET.

SIR,—The notes of the following case may be of interest to the readers of THE LANCET.

G. A——, aged forty, spare and delicate, awoke suddenly, on the morning of the 8th instant, with excruciating pain in the right knee. I saw him at 8.30 A.M. and found the right patella dislocated outwards and vertically. The anterior surface of the patella looked forwards and inwards. The internal edge was firmly wedged into the notch between the two condyles of the femur. I attempted reduction, but unsuccessfully. The result of an examination of the heart and lungs was that it would be extremely hazardous to administer an anæsthetic. Hot fomentations were ordered to be applied round the knee. Two hours afterwards I saw him, in conjunction with Dr. McColl of Hebburn. We attempted reduction, but again unsuccessfully. Dr. McColl considered the use of anæsthetics would be highly dangerous; the man was evidently much exhausted. We resolved to let him recruit a little before attempting reduction again. I was detained by other matters, so that he was not seen till 10 A.M. on the 9th instant. On visiting him I found the patella reduced to its normal position. He was awakened about 4 A.M. by severe pain in the knee, and on examination he found the knee all right again. I may add this is the fourth time the same patella has been dislocated. The first three times reduction took place under chloroform. I am, Sir, yours &c.,

Jarrow-on-Tyne. JOHN N. WILSON, M.B., C.M.

A CASE OF TYPHOID THE RESULT OF GASTRIC FEVER.

To the Editor of THE LANCET.

SIR,—I am now attending a case of typhoid, the outcome of a case of so-called gastric fever. The parents, ignorant in their own wisdom, ascribed little importance to the case of so-called gastric fever, and hence the consequence. Similarly I believe it is frequently noticed that cases of so-called scarlatina are followed by the worst possible form of scarlet fever. Surely the time has arrived for practitioners generally to recognise only typhoid and scarlet fever (mild and severe), and not assist in perpetuating such fatal errors.—I am, Sir, yours, &c.,

A. KINSEY MORGAN,
Medical Officer Harwich Urban and Port
Jan. 31st, 1882. Sanitary Authority.

CONCEALMENT OF BIRTH AT LEEDS.

WE are glad to see the *Leeds Mercury* condemn the terms in which a jury thought fit to express their opinion of Mr. Foster in regard to his action and evidence in a case of concealment of birth. The report of the trial is too imperfect for us to give an elaborate opinion. But we see nothing in this report to justify the severe menace of the judge and, still less, the disparaging opinions of the jury, who do not magnify their office by trying witnesses.

C. T. J. O'Rork.—We regret that extreme pressure has prevented our noticing the important subject alluded to by our correspondent. We hope to do so next week.

Mr. G. W. Sparke.—The Albert Medal was given to Dr. Lowson, of Huddersfield, in June last. See THE LANCET of June 25th, p. 1035.

"WANT OF HONOUR AMONGST FRIENDS."

To the Editor of THE LANCET.

SIR,—In answer to the letter of "B. and D." of the 11th inst., I will confine myself to the actions of the doctor. He is called in the early morning to a case which requires the aid of a surgeon. He at once tells the mother that an operation is necessary, and that he will go and fetch a surgeon, D., and starts. He admits that when a few yards on his way he thought of me, and that I had some little connexion with the family in some way or other; but, nevertheless, he went to D. without giving the family the option of employing their own surgeon, who lives about thirty yards more distant than D. Surely the thirty yards extra would not be of great importance in this case.

I have attended the head of the family solely since 1876 every year, also a son who broke his arm last year at football in the doctor's field adjoining his house. I have met the doctor at the house when we have been attending different members of the family at the same time, so that one is justified in supposing that he knew some surgeon attended the family, and most probably I was the one.

The doctor asks, "Is a physician entitled, nay, even bound, to select at his own discretion?" The reply must be decidedly "No." The physician's duty is to consult with the regular surgeon to the family. If he is not capable of performing the operation, then the physician is entitled to select at his discretion.

I have been driven to report this case in THE LANCET because I think, under the circumstances, I have not been treated fairly, and I should like to obtain the opinion of the profession regarding it. We are all three friends and colleagues at the hospital in this town.

I am, Sir, yours faithfully,
Feb. 13th, 1882. A CONSERVATIVE.

*** There is one slight but important inaccuracy, as we read these letters, in the statement of "Conservative." From the above letter we should gather that "when a few yards on his way for a surgeon," the doctor "remembered 'Conservative's' connexion with the family." The doctor, on the contrary (see letter of "B and D," Feb. 11th), says "until after the operation this circumstance entirely escaped the recollection of B, otherwise it might possibly have altered his selection." If "A Conservative," with whose ethical views, on the whole, we agree, will consider this point and the general spirit of the letter of "B and D," we think he will agree with us that this matter might fairly end here without discredit to any of the parties concerned.—ED. L.

TREATMENT OF PAINFUL MAMMÆ.

To the Editor of THE LANCET.

SIR,—Allow me through the medium of your valuable journal to call the attention of my professional brethren to what I hope will prove a valuable discovery, and save much disagreeable trouble. Some time since I was called to attend a lady who had recently lost her baby. I found her in a state of high fever, her breasts very full, hard, and painful. It was some distance from town, and I had no plaster or belladonna with me, neither could I get either at once, so I thought I would try pressure. With this object I applied firmly an ordinary rib bandage round and round the chest, over the breasts, starting on a level with the arm-pits, and continuing down until the breasts were firmly enclosed. When I called the next day I found the breasts very much softer, free from pain, and the feverish symptoms entirely gone, and after a few days the breasts ceased to give any trouble. Since then I have never in a similar case used either plaster or belladonna, but depended entirely on the bandage used as before mentioned, and every time with the greatest success—in fact, with a better result than I had ever obtained with either plaster or belladonna. Trusting the (to me) importance of this discovery may excuse the length of this letter, I remain, Sir, yours truly,

HENRY PIGEON, M.R.C.S. Eng., L.R.C.P. Edin.
Clifton.

F.R.S. Ed.—M. Favot, of Paris, published a very interesting book in 1867 on Inhumation and Incineration, in which he states that the original inhabitants of Florida used to burn the bodies of medical men only; they then carefully collected the ashes, mixed them with water, and drank the latter to keep off diseases. The work was reviewed in THE LANCET, Nov. 9th, vol. ii., 1867, p. 584.

Editor R.D.—The question is put in too indefinite a form to admit of a satisfactory reply. Application had better be made to a bookseller.

PUERPERAL FEVER: RECOVERY.

To the Editor of THE LANCET.

SIR,—During the last ten years I have met three cases of puerperal fever; the first was about eight years ago. Knowing its danger, I sought consultation with our most distinguished gynæcologist here. The result was fatal. The second case was about four years later. The confinement was attended by a gentleman of acknowledged ability and long experience. As the patient was getting worse, at the request of her friends I was called in. All the usually recommended means were tried. The result was again fatal.

One practitioner in my neighbourhood, most of whose experience is obstetric, lost some short time ago four patients in a few weeks, and had no case of recovery. The late Dr. Tyler Smith wrote, "About 3000 mothers die in childbed annually in England and Wales. This is an average of nearly eight deaths every day from this cause. The mortality occurs for the most part to women in the prime of life, and previously with enjoyment of full and vigorous health. Amongst the causes of death puerperal fever is, of all others, the most important and fatal." This detail, coupled with the experience narrated above, filled my mind with sad forebodings when the third case of this dread visitor appeared.

On Monday evening, Jan. 30th last, I attended a confinement—a young and healthy woman. On Tuesday morning I visited and found pulse 80, and every symptom most favourable. On Wednesday morning, Feb. 1st, my patient felt so well that she expressed her ability and wish to get up, which of course she did not attempt. On Thursday, 2nd, at 12.30 P.M., I paid my usual visit, and heard that my patient had "a severe shake" the night before. I found her bathed in perspiration. Pulse 120; temperature in axilla 102·5°. Lochial discharge almost suppressed, and the other usual symptoms. I gave the ordinary directions, &c., and visited again at 5.30 P.M., when the hydrosis was as copious as before. Tympanitic distension visible; pulse, temperature, &c., unaltered. Friday, Feb. 3rd, morning visit, no change for better; poultices, &c., continued. Evening visit, no change for better; stomach sick; tympanites increased. I requested the nurse to send the husband to me as soon as he returned from his employment, as I considered the case most serious. He called about 9 P.M. I gave an eight-ounce bottle containing two drachms of tincture of aconite, and the direction "Half a tablespoonful every two hours." Saturday, 4th, morning visit: Two-thirds of the medicine taken. Perspiration almost gone. Temperature 101°; pulse 92. Expressed herself as feeling much better. Subsequent recovery rapid.

I do not know if this medicine has been tried in such cases by others. However, I feel assured its use is not generally known, and therefore I write in the hope that it may prove as great a source of joy to others as it has to me, and would esteem it a kindness if some one, induced by this letter to try it, would favour me with the result.

I am, Sir, your obedient servant,
Liverpool, Feb. 11th, 1882. W. H. LAMBART, M.D., M.R.C.S.

X. K.—There is at present no Board of Examiners for the Licence in Midwifery of the Royal College of Surgeons of England. Some years ago the members of the Board resigned, and the further appointments have been deferred.

L.R.C.S.I. should apply to the office of the Crown Agents for the Colonies, Downing-street.

Mr. Latley.—Too late.

A. H. Noson.—Certainly not. He will, of course, act with consideration in regard to urgent cases.

Dr. Wallian (Bloomingdale).—We cannot exchange.

EXCESSIVE SNEEZING.

To the Editor of THE LANCET.

SIR,—In reply to Mr. L. H. Pegler as to the best method of treating this affection, will you allow me to refer him to section 508.3 of your humble servant, where he will find a guide to much information upon the subject. In a few months I hope to contain further information upon this and other matters, and in the meantime would direct attention to Dr. Russell's case due to cerumen, *British Medical Journal*, vol. ii., 79, p. 937, and Dr. Woakes's paper in THE LANCET, March, 1880, p. 353, as well as to other cases recorded in THE LANCET, Nov. 1872, p. 804, and in the Journal Jan. 1880, p. 90, and Dec. 1879, p. 1021.

I am, Sir, yours faithfully,
Feb. 14th, 1882. MEDICAL DIGEST.

VACCINATION.

To the Editor of THE LANCET.

SIR,—It is just possible the following extract on this question may interest a few of your readers who have not had occasion to peruse "A Lady's Cruise in a French Man-of-War," by C. F. Gordon Cumming, just published:—"Their [Mr. Turner and assistants in charge of a district in Samoa] chief care, however, was to vaccinate every man, woman, and child within reach, a precaution to which may be attributed the happy circumstance that there has never been a case of small-pox in Samoa, though it is visited by so many foreign ships. In many other groups, where some chance vessel has touched, the deadly infection has been left, and in some cases a third of the population has died."—Vol. i., page 186.

I am, Sir, yours, &c.,
Feb. 10th, 1882. A. B. RAILTON.

"NIGHT DEMANDS ON MEDICAL MEN."

To the Editor of THE LANCET.

SIR,—I have read with some interest your comments under the above heading in your issue of the 28th ult. It is much to be deplored that a man in dire extremity of sickness should be unable to obtain medical aid, and the case referred to must be a very exceptional one. Yet there is something instructive in the fact that finally a "young" surgeon went to his relief. Probably the six who refused were gentlemen with many years' experience not only in the practice of the profession, but in the deceptions and artifices that are often resorted to by thoughtless persons to drag a doctor out of his bed. The young surgeon had not the latter experience, and so, greatly to his credit, promptly responded to the summons. I do not defend the erring six, because no doubt from a moral standpoint they were wrong; but the public are greatly to blame for the cool way in which they trifle with medical men by demanding their services on any and every occasion without offering remuneration or even bare thanks in return.

To illustrate what I mean let me take my own case. I have been twenty-five years in practice, and of course have done a great deal of gratuitous work. On many scores of occasions I have been called up at night, often to go long journeys, not only without any prospect of a fee, but to find some trivial ailment that might well have been treated without a visit had an intelligent messenger or a note been sent instead of a peremptory summons. In other cases the patient had been ill all the previous day, when help might have been easily obtained. But people who do not intend to pay have no occasion to consider whether a day or a night visit is the more costly. In further illustration, on the night of the 26th ult., or rather at 1.30 in the morning, I was sent for to see a girl whose only complaint was griping, the result of taking two quack pills. There was no fee or chance of one, her friends being very poor. The next night I was at a social gathering that kept me out of bed till half-past three. The following night, after a hard day's work, I was summoned to three cases, as follows:—1st, at 10 P.M., a child with bronchitis, ill several days, and comfortably asleep on my arrival; 2nd, at 1.30 A.M., a young married woman faint and hysterical at the period of quickening, had been ill all day; 3rd, at 3.45 to a child of a labouring man that had caused great alarm to its parents by passing a very offensive motion. In neither of these cases did I receive, nor do I expect, any fee.

The following day (Sunday), theoretically a day of rest, brought the usual round of visits, and here again we are at a disadvantage. There is no chance of recovery from the toils and fatigues of the week by the enjoyment of the blessed rest of Sunday. To the busy practitioner every day is the same, complete rest being a thing undreamed of.

Such cases as those I have given above frequently occur, and, after a time, tend to harden our hearts against hasty summonses, or, at any rate, to raise a doubt as to the extent of the malady for which relief is sought. I am afraid to say how many times I have been hurried off to a person said to be "just dead" or "just gone," to find on my arrival that "a drop too much" was the only disease.

Your suggestion as to a public night medical service is a good one, but could hardly be adopted in small towns. The best remedy is fair play. If the public will treat medical men fairly, and not deliberately cheat them out of their rest, time, and skill, such complaints as those of your lay correspondent would never be heard of.

I am, Sir, yours truly,

Feb. 1st, 1882. A GENERAL PRACTITIONER.

SELF-MUTILATION.

To the Editor of THE LANCET.

SIR,—"A Medical Student" will find in THE LANCET of Oct. 17th, 1863, a remarkable case of complete self-mutilation. The man in question had made a clean sweep of everything, and arrived at St. George's Hospital with the detached organs in his coat-pocket.—I am, Sir, yours, &c.,

Jan. 31st, 1882. A. B. B.

ERRATUM.—Near the end of our leading article on Ambulances last week, speaking of gentlemen who had interested themselves in the promotion of these means of transit for the sick and injured, the name of Mr. Richard Davy was misprinted "Day."

COMMUNICATIONS not noticed in our present number will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from—Professor Charteris, Glasgow; Professor Pirrie, Aberdeen; Professor Maclean, Netley; Dr. Brown-Séquard, Paris; Dr. Buzzard, London; Mr. Grün, Putney; Dr. Orange, Broadmoor; Mr. Eales, Birmingham; Dr. Fleck, Brighton; Mr. Newton, Huntingdon; Mr. G. A. Brown, Tredegar; Mr. Arnold, Belfast; Mr. Railton, London; Mr. Haggard, London; Mr. R. Knocker, Bown; Mr. Mulvany, Portsmouth; Mr. McAldowie; Mr. Thos. Holmes, Leeds; Mr. Turner; Dr. Barford, Wokingham; Mr. Kesteven, London; Dr. Ewart, London; Mr. Joseph Williams, Brentford; Dr. Steele, Rome; Surgeon Blair Brown; Dr. Sandford, Hereford; Dr. Ridge; Mr. Howard, Sandgate; Mr. Davy, London; Dr. Laseron; Dr. Williams, Bloomingdale, U.S.A.; Dr. Lambart, Liverpool; Mr. Bourne, Mansfield; Mr. Malcolm Morris, London; Dr. Douglas Powell, London; Dr. Whitson, Glasgow; Mr. Pollard, Baildon; Mr. W. Powell, Cheltenham; Dr. Norman Kerr; Dr. Shea, Wokingham; Dr. Simons, Luton; Dr. Sturges, London; Mr. Dolan, Halifax; Mr. F. H. Weiss, London; Mr. Saul, London; Mr. Davis, Chelmsford; Dr. Stainthorpe, Purbeck; Mr. Rouë, Bristol; Mr. Berry, Keighley; Messrs. Savory and Moore; Messrs. Nieclay; Mr. Clacher, New York; Messrs. Vesey and Co., Bath; Dr. Warren; Mr. Stocker Messrs. Beale and Co., Brighton; Messrs. Pinchard and Son, Taunton; Dr. Sadler, Barnsley; Mr. H. A. Reeves, London; Mr. Hudson, Leeds; Dr. Colombo, Milan; M. Vitali; Dr. Miller, London; Dr. Elliott, Hull; Mr. Gravely, Chailey; Dr. Ash, Holdsworthy; Mr. Markham, Portsmouth; Dr. Boyd, Southall; Dr. Ruck, Ohio; Mr. Mecklehose, Glasgow; Mr. Parker, Stafford; Mr. Greene, Dublin; Dr. Stretton, London; Doctor, London; Editor R.D.; E. J. G.; Fog Destroyer; Adi; Diabolus; M.D., M.Ch.; Epsilon; H. C.; &c., &c.

LETTERS, *each with enclosure*, are also acknowledged from—Dr. Eberle Thirsk; Messrs. Pocock and Co., London; Messrs. Lewis and Bell Rochester; Messrs. Simpson and Jackson, Coggeshall; Mr. Beasley, Rowley Regis; Dr. Richardson, Appleby; Mr. Webb, Fleetwood; Mr. Arkle, Morpeth; Mr. Brown, York; Dr. Walker, Cheltenham; Mr. Pollitt, Kendal; Mr. Noot, Porlock; Dr. Hern, Darlington; Mr. White, London; Mr. Roberts; Mrs. Iles, Fairford; Mr. Christian, Alderburgh; Mr. Reynolds, Isle of Man; Messrs. Smith and Son, Dublin; Mr. Browett, Coventry; Mr. Woodison; Messrs. Schacht and Co.; Dr. Tylecote, Sandon; Mr. Hindle, Chorley; Dr. Dive, Kenley; Mr. Laig, Saxmundham; Dr. Waugh, Bathgate; Dr. McEnery, Cerne Abbas; Mr. Knaggs, Huddersfield; Mr. Smith, Hunalet; Mr. Horne, Bootham; Mr. Birchall, Liverpool; Mr. Brooks, Hull; Mr. Jones, Sheffield; Mr. Harrison, Sunderland; Mr. Burnett, Motham; Mr. Van Praagh, London; Mr. Loeflund, Stuttgart; Mr. Jones, Dowlais; L.R.C.P., Faversham; Alpha, Manchester; Country; Practitioner, York; Doctor, Tamworth; J. G., Glasgow; C. R.; X. Y. Z., Thame; Medicus, Warrington; X.; North London; C. H., Catford; Doctor Liskeard; F.R.C.S.E.; N. W. R., Liverpool; R. A.; Blackfriars; H. E., Atherstone; Forceps, London; J. A. P., Nottingham; S. B., St. Leonards; E. J., London; L. M., Southampton; Medicus, Paddington; M., Cork; A. J.; J. H. C., Manchester; &c., &c.

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